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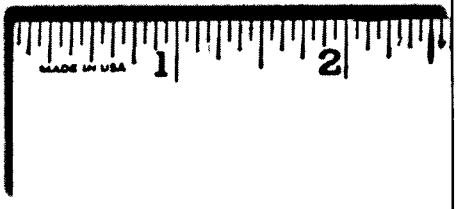
ABSTRACT

This report presents findings from a recent evaluation of 51 school health education programs nationwide. All programs were currently functioning and ongoing, had been evaluated, and provided some evidence of effectiveness. Each program was designed to improve the short- or long-term health status of children and youth in a school-based or school-linked setting. Most of the programs were self-contained within one component, such as health education. All programs submitted program descriptions and evaluation data. Reviewers critiqued evaluation designs, appropriateness of instruments used to measure key variables, and presence or absence of comparison groups. They determined the degree to which programs addressed critical needs, the extent to which they were distinctive, and the complexity of problems being tackled. They also commented on the probability that others could successfully duplicate the programs or were certain of their components in other places and with other audiences. For each program, the report includes the following information: program description, services available, implications for practice, evidence of program effectiveness, critique, and contact information. (Contains approximately 200 references.) (SM)

SCHOOL HEALTH

Findings from Evaluated Programs



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

SCHOOL HEALTH:

FINDINGS FROM EVALUATED PROGRAMS

Second Edition
1998

developed by
the American School Health Association
in collaboration with
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
Public Health Service

Programs described in this publication represent a sampling of school health programs that have been evaluated. Findings presented in this document are based on publications or other available reports written by the program designers and/or evaluators. Inclusion of a program description in this publication does not imply endorsement by the Public Health Service, U.S. Department of Health and Human Services or any other agency of the U.S. Government. Similarly, omission of a program does not imply a negative judgment about that program. There are many school health programs around the Nation which may have been evaluated but are not included in this publication.

Acknowledgements

This compendium of evaluated school health programs represents the efforts of many individuals from across the nation interested in promoting school health. Preparation of this document involved individuals in private and public schools and universities, community organizations, as well as local, state and federal governments.

The Public Health Service, through its Office of Disease Prevention and Health Promotion, entered into a cooperative agreement with the **American School Health Association** to compile this report on school health programs. Staff associated with ASHA who participated in the project include: **Marcia Rubin**, PhD, MPH, Project Director; **Susan Wooley**, PhD, Project Editor; **Scott Rainone**, Publication Coordinator; **Alaina Giltz**, MS, Project Assistant; **Kyu Kyu San**, Project Assistant; and **Marjorie Benjamin**, Administrative Assistant. **Kristine McCoy**, MPH, and **Nicole Cumberland** provided oversight for this project on behalf of the Office of Disease Prevention and Health Promotion.

We wish to thank all the individuals who sent information on evaluated school health programs as well as those who reviewed the programs.

Contents

Introduction

In 1990, the U.S. Public Health Service's Office of Disease Prevention and Health Promotion released *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*[1] that outlined over 350 objectives to improve the health status of Americans during the current decade. A third of the objectives were related to the health needs of children and youth. The most pressing issues for children and youth, including injury and violence, poor nutrition, inadequate physical activity, tobacco use, alcohol or other drug use, and early sexual activity, are complex and interactive. A myriad of factors – socioeconomic, cultural, psychosocial, environmental and genetic – influence these issues and no single program or strategy, by itself, is likely to improve health behaviors.

Schools are ideal places to reach children and youth. Because children's health and learning are linked, children cannot learn when they are not well or when health concerns interrupt their ability to concentrate. For this reason, schools are specifically identified in 13 of *Healthy People 2000*'s objectives (see figure 1). Objective 8.4 calls for increasing to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten to 12th-grade comprehensive school health education.

Comprehensive school **health education** is "classroom instruction that addresses the physical, mental, emotional, and social dimensions of health; develops health knowledge, attitudes and skills, and is tailored to each grade level."[2] Schools with comprehensive school health education meet the following criteria: a documented, sequential program; at least one health education course; instruction in six key behavioral areas; focus on skill development; health education teachers adequately trained; designated coordinator of health education; involvement of parents, health professionals and other concerned community members; and evaluation of health education program during the past two years.

The World Health Organization[3] noted that quality health education:

- views health holistically, addressing the interrelatedness of health problems and the factors that influence health, within the context of the human and material environment and other conditions of life;
- utilizes all educational opportunities for health: formal and informal, standard and innovative curriculum and pedagogy, and opportunities available within and outside of the school;
- strives to harmonize the health messages from the various sources that influence students, including messages from the media, advertising, the community, the health and development systems, family and peers, and the school; and
- empowers children and youth to act for healthy living and to promote conditions supportive of health.

Health education or instruction is one of several related components in a school health program. "A **comprehensive school health program** is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social and educational development of students. The program involves and is supportive of families and

figure 1:

Healthy People 2000 school objectives

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities.

2.17 Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutrition principles in the *Dietary Guidelines for Americans.*

2.19 Increase to at least 75 percent the proportion of the nation's schools that provide nutrition education from pre-school through 12th grade, preferably as part of comprehensive school health education.

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of comprehensive school health education.

4.13 Provide to children in all school districts and private schools primary and secondary educational programs on alcohol and other drugs, preferably as a part of comprehensive school health education.

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of comprehensive school health education.

determined by the local community based on community needs, resources, standards, and requirements. It is coordinated by a multi-disciplinary team and accountable to the community for program quality and effectiveness."[4] The complexity of the environmental and bio-psychosocial factors that influence the health and learning of children and adolescents requires a well-coordinated, comprehensive approach in which schools deliver multiple health promotion and risk reduction strategies in various, developmentally appropriate formats over several years.

A widely accepted model of a comprehensive school health program[5] includes, in addition to health education:

- **clinical health services:** preventive services, education, emergency care, referral and management of acute and chronic health conditions;[2]
- **psychosocial support services:** activities that focus on cognitive, emotional, behavioral and social needs of individuals, groups and families;[2]
- **health environments:** the physical, emotional and social climate of the school;[2]
- **school nutrition services:** integration of nutritious, affordable and appealing meals; nutrition education; and an environment that promotes healthy eating behaviors for all children;[2]
- **physical education:** planned, sequential instruction that promotes lifelong physical activity;[2]
- **health promotion for faculty and staff:** on-site assessment, education and fitness activities for school faculty and staff;[2] and
- **family and community involvement:** partnerships among schools, families and community groups and individuals.[2]

American schools have implemented a variety of health program components with variable degrees of comprehensiveness, coordination and success. Progress on meeting the *Healthy People 2000* objectives for schools remains sporadic.

Because school health programs have the potential to meet the immediate health needs of children and youth as well as establish the foundation for lifelong habits that ultimately improve health status, program planning and adoption decisions should consider evidence of effectiveness. To help meet these needs, the first edition of *School Health: Findings from Evaluated Programs* offered a sampling of 63 evaluated programs across the eight components of the school health model (see figure 2). Building on that effort, this second edition includes 51 programs not previously reviewed. This edition seeks to balance presentation of program goals and objectives with what programs have accomplished based on evidence of effectiveness. The summaries contained herein could help both those interested in implementing a quality school health program and researchers and evaluators looking for evaluation models or unanswered questions.

Selection Criteria

The criteria to select programs for inclusion in the second edition were:

- **implementation site**: all programs are either school-based or school-linked;
- **currency**: all programs are currently functioning and on-going;
- **history**: all programs have been in existence at least three years; and
- **evaluation**: all programs had been evaluated and provided some evidence of effectiveness.

Review Process

All the programs included in the second edition submitted evaluation data in addition to program descriptions. Materials submitted included articles published in peer reviewed journals and reports prepared for funders, program developers or an oversight group. Some of the included programs had received extensive review by an outside panel of reviewers such as the U.S. Department of Education's Program Effectiveness Panel. Program evaluations that had not undergone review by such a committee were sent to three reviewers for critique of strengths and weaknesses. A list of all the reviewers follows the introduction. The review guidelines are found in Appendix A.

Evaluation

Evaluation is a specialized branch of the social sciences. Many highly-skilled health and education professionals have little or no background in evaluation. As a result, the evaluation reports of many school health programs have very poorly designed evaluations and fail to demonstrate program success or account for limitations in claiming success. In the first edition, the U.S. Public Health Service made no attempt to determine the quality or validity of the methodology used in evaluating the included programs. This second edition has paid greater attention to the strengths and weaknesses of the evaluation studies in order to help individuals determine the appropriateness of a program for their particular circumstance. The brief primer on evaluation below will help readers understand the implications of and distinctions between the various types of evaluations in the program reviews.

Types of Evaluation

Evaluations take many forms including formative, process, or summative. "Formative" evaluation gathers information for developing or modifying a program to improve its success. It often occurs in the early stages of a multi-year initiative and prior to major implementation. "Process" evaluation examines the effectiveness of program logistics, what was done and how it was done. For example, process evaluation might ask how many meetings occurred, how many people came, how many fliers were distributed? Was the meeting time and place convenient? Was an activity delivered as planned and if not, why not? "Summative evaluation" can examine "outcomes" or "impact." "Impact" evaluation examines the immediate effects of program activities and strategies on changes in knowledge, attitudes, skills and behaviors. For example, after providing a teacher in-service program on role playing strategies, impact evaluation might assess whether teachers expressed increased confidence in using the strategy or determine what percent actually applied the techniques in the classroom. "Outcome" evaluation requires long-term follow-up. In the previous

figure 1 (cont.):

8.2 Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health.

8.4 Increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade comprehensive school health education.

8.5 Increase to at least 50 percent the proportion of post-secondary institutions with institution-wide health promotion programs for students, faculty, and staff.

9.18 Provide academic instruction on injury prevention and control, preferably as part of comprehensive school health education, in at least 50 percent of public school systems, kindergarten to 12th grade.

9.19, 13.16 Extend requirement of the use of effective head, face, eye and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury.

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV curricula for students in fourth through 12th grade, preferably as part of comprehensive school health education.

19.12 Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of comprehensive school health education.

figure 2:

School Health: Findings from Evaluated Programs
(first edition, 1993)

- ADEPT
- Adolescent Health Prevention Trial
- AIDS Education Pilot Study
- Alcohol Misuse Prevention Study
- CHAMPS HIV/ AIDS Prevention
- Changing The Course
- Dietary Change Program for 10th Graders
- Every Child a Winner
- Exercise Programs for Children
- Exeter-Andover Project
- Feelin' Good
- Future Fit
- Gillespie Student Health Project
- Go For Health
- Great Sensations
- Growing Healthy
- Health Enhancement Program
- Health Promotion for Educators
- Health Promotion for School Personnel
- Health Start
- Healthy Lifestyles Program
- Heart Healthy Eating and Exercise
- Hearty Heart
- Here's Looking at You, Two
- I'm Special Program
- Know Your Body
- Life Skills Training
- Middletown Adolescent Health Project
- Midfield Safety Belt Incentive Program
- Minnesota Smoking Prevention Program
- Nutrition for Life
- Nutrition/Changing World

example, an outcome evaluation might follow the students whose teachers participated in the in-service to see if their grades improved or if they abstained from tobacco use or sexual activity. Summative evaluation usually includes data from a control or comparison group.

People select different types of evaluations for different reasons. Sometimes program planners want information about how well a program meets the needs of program staff or the individuals served. Policy makers use program evaluations when making decisions. They are often more concerned about progress relative to past performance than compared to an outside control or comparison group. Such program evaluations can involve a wide range of sophistication and thoroughness but are generally limited to consideration of a particular program in a specific location.

Research evaluation generally compares one program model against another to detect statistically significant differences. The gold standard in research is having similar groups of individuals randomly assigned either to a new program or to a standard, usual practice program. An outside group, without knowledge of which group is which, then collects impact and outcome information to determine if the new program was more effective than the traditional program in bringing about the desired result. When conducting evaluations in schools, this model is seldom possible. Instead, researchers use quasi-experimental models that compare individuals in some classrooms within a school to individuals in other classrooms within the same school or compare one school to another school in the same district or in another community. Wide spread program implementation and evaluation with similar results in a variety of settings (e.g., urban, rural, and suburban schools in the northeast and southwest, with all ethnic groups) increases confidence that the program will consistently produce similar results. The closer a study comes to this ideal, the more likely the findings are due to the program rather than some other factor such as teacher skill, family background of the students or time.

Types of Data

Program evaluation and research studies gather quantitative and/or qualitative data. Quantitative data is information that can be counted or measured in numbers (e.g. how many people attended, changes in test scores from pretest to posttest, incidents of violence before and after the program). Qualitative data is information gathered by direct questioning or observation. This ethnographic approach often helps explain why something occurred, going beyond just documenting that something happened.

Caveat Emptor

For this second edition, reviewers critiqued evaluation designs, appropriateness of instruments used to measure key variables and the presence or absence of comparison groups. They determined the degree to which programs addressed critical needs, the extent to which programs were distinctive and the complexity of problems being tackled. They also commented on the probability that others could successfully duplicate the program or certain of its components in other places and with other audiences. Readers should consider the quality of the research design, the reported findings and the critique when assessing the effectiveness of programs summarized in this edition. Many apparently well-designed programs had flawed evaluations that failed to convince reviewers that the evidence demonstrated

effectiveness. In addition, many of the programs reviewed were "works in progress" and today many differ significantly from when they were evaluated. Despite these caveats, the programs reviewed in this edition offer many lessons and we encourage you to contact the individuals most directly involved for more information.

Summary

The second edition of *School Health: Findings from Evaluated Programs* is a compendium of programs not already reviewed in the first edition. Each program is designed to improve the short term or long term health status of children and youth in a school-based or school-linked setting. They offer a wide variety of strategies and address multiple issues in different audiences. Many of the programs have existed for several years and are well known in certain disciplines but not widely known to other professionals who work in schools.

Every effort was made to identify evaluated programs in each of the eight components of a comprehensive school health program and the reviews include 35 in Health Education/Instruction, four in Clinical Health Services, three in Physical Education, six in Psychosocial Support Services, three in Healthy Environments, three in School Nutrition Program and 11 Family and Community Involvement. No programs were identified for Faculty and Staff Health Promotion programs. Several programs address the National Education Goals, as well as many of the objectives in *Healthy People 2000*. Quick reference tables, which follow the introduction, have been included to help readers quickly identify areas of interest. Table 1 graphically represents the match between reviewed programs and the eight components of a comprehensive school health model, while Table 2 displays selected *Healthy People 2000* priority areas.

The majority of the programs tended to be self-contained within one component, such as health education. Several of these programs linked the classroom curriculum with parent and family involvement. A few programs, such as CATCH, had multiple program components that made significant advances toward a truly coordinated school health program.

Many of the programs relied on theories from the fields of psychology, sociology, education, and epidemiology to develop their intervention strategies. Social learning/cognitive theories dominated but control theories and a variety of developmental and social relationship theories were also represented and reflect the rich, multi-disciplinary tradition on which school health programs are based.

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4. Institute of Medicine, Committee on Comprehensive School Health Programs, Division of Health Sciences Policy. Allensworth D, Lawson E, Nicholson L, Wyche J, eds. *Schools and Health*. Washington, DC: National Academic Press. 1997.
5. Allensworth D, Kolbe L. The comprehensive school health program: exploring and expanded concept. *J Schl Health*. 1987; 57(10):409-412.

figure 2 (cont):

- Pawtucket Heart Health Program
- Peer Power and ADAM
- Positive Youth Development Program
- Postponing Sexual Involvement
- Project ACCEPT
- Project ALERT
- Project Model Health
- Project PRIDE
- Project SMART
- Reducing the Risk
- Reproductive Health Programs of Six School Based Clinics
- San Diego Family Health Project
- San Francisco AIDS Prevention Education
- School-Based Adolescent Health Care
- School Health Demonstration Program
- School/Community Sexual Risk Reduction
- Seattle Children's Bicycle Helmet Campaign
- Self Center Program
- Solid Waste Reduction Program
- Stanford Adolescent Heart Health Program
- Students for Wellness
- Suicide Awareness Curriculum
- SUPER II Program
- Teenage Health Teaching Modules
- Television, School and Family Project
- Testicular Self-Examination Program
- Three Intervention Programs
- Three Rs And HBP
- Westchester County Occupant Restraint Program
- Youth Development and Substance Use Prevention

Program Reviewers

Howard Adelman, MD
University of California – Los Angeles

Amita Bhatt, MHS
Johns Hopkins University

Kris Bosworth, PhD
Indiana University

Claire Brindis, DrPH
University of California – San Francisco

Kelli McCormack Brown, PhD
University of South Florida

Brian Colwell, PhD, CHES
Texas A & M University

Linda B. Crider, PhD
University of Florida

Kevin Dwyer
National Association of School Psychologists

Jill English, PhD
California State University – Fullerton

Oliver E. (Gene) Ezell, PhD
University of Tennesee – Chattanooga

Gail Carter Frank, DrPH
California State University – Long Beach

Dawna Fuqua-Whitley, MA
Emory University

Susan Scavo Gallagher, MPH
Children's Safety Network/ Education Development Center

Nicholas K. Iammarino, PhD
Rice University

Delores C. S. James, PhD, RD
University of Florida

Arthur L. Kellermann, MD, MPH
Emory University

Molly Laflin, PhD
Bowling Green State University

Lynette K. Lawrance, PhD
University of North Carolina – Greensboro

Susan R. Levy, PhD
University of Illinois

Leslie Lytle, PhD
University of Minnesota

Bonnie Nastasi, PhD
University of Albany, SUNY

Kweethai Chin Neill, PhD
Sam Houston State University

James J. Neutens, PhD
University of Tennessee – Knoxville

David Osher, PhD
Institutes for Research

Cheryl L. Perry, PhD
University of Minnesota

Margaret Raynal
University of Florida

Barbara A. Rienzo, PhD
University of Florida

Laurna G. Rubinson, PhD
University of Illinois

John Santelli, MD
Centers for Disease Control and Prevention – DASH

Mark Swerdlik, PhD
Illinois State University

Susan K. Telljohann, PhD
University of Toledo

Nancy O'Hara Tompkins
West Virginia University

Robert F. Valois, PhD
University of South Carolina – Columbia

Chudley E. Werch, PhD
University of North Florida – Jacksonville

Alice Whiren, PhD
Michigan State University

Key to Ready Reference Bars

A ***Ready Reference Bar***, which appears on the edge of each page, allows readers to quickly review the program and evaluation highlights.

Program Components

Audience	P	Pre-Kindergarten
	K^3	Primary Grades (K-3)
	4^6	Upper Elementay (4-6)
	M	Middle School
	H	High School
	K^{12}	Kindergarten to 12th
	S	Special Education

Locale	R	Rural
	U	Urban
	S	Suburban
	M	Multiple

Level	Cl	Classroom
	B	Building
	D	District
	Co	Community

Components	C	Curriculum
	St	Staff Development
	Pe	Peer Involvement
	Pa	Parent Involvement
	M	Media
	P	Policy
	Sk	Skills
	Se	Service Learning

Emphasis	K	Knowledge
	A	Attitudes
	N	Norms
	B	Behaviors

Evaluation Information

Experimental	E	Design
Quasi-experimental	Q	

Individual	I	Analysis
Group	G	
Building	B	
District	D	
Community	C	
Multiple	M	

Qualitative	Ql	Data
Quantitative	Qn	
Both	B	

Formative	F	Type
Summative	S	
Outcome	O	
Process	P	

ACHIEVE

Program Description

Project ACHIEVE is a school-wide reform process developed in 1990 by the University of South Florida's School Psychology Program in conjunction with several school systems to improve the academic and social progress of at-risk and underachieving students in Chapter I schools. The target population is elementary schools students. *ACHIEVE* has now expanded to similarly challenged schools across the country.

ACHIEVE places particular emphasis on improving students' social behavior and aggression control and reducing incidents of school-based violence. An assumption of the project is that special education is not an appropriate intervention for all children with school-related problems. Thus, *ACHIEVE* helps teachers and other educators accurately identify and confirm why specific problems exist and then determine the best approach to address the problems. Another assumption is that a student's intervention needs and the school's ability to address those needs should dictate the intervention setting; a student's perceived disability or label should not be the basis.

The program has six primary goals. They are to: 1) enhance teachers' problem-solving skills; 2) improve teachers' classroom management skills of teachers and at-risk students' classroom behavior; 3) to improve the school's comprehensive services to students with below-average academic performance; 4) to increase students' academic and social progress; 5) to assess various components of *ACHIEVE*; and 6) to create a climate where school staff believe they are responsible for every student.

The project requires staff and resources found in most Chapter I schools including: a school counselor, school psychologist, school social worker or parent educator, instructional specialists, speech or language therapist and a school nurse. In addition, a full time project manager coordinates the processes and services. Because of the multiple facets involved in whole school reform, *ACHIEVE* occurs as a series of carefully sequenced steps over a period of three years. This gradual change maximizes staff acceptance, provides skill training in a sequential order with increasing complexity, insures the existence of classroom-based technical support and consultation and facilitates accurate data collection that measures outcomes and demonstrates accountability.

Services Available

The project provides training in problem-solving, social skills and anger management, effective teaching, curriculum-based assessment, parent education and training in social and academic behavior, organizational planning, organizational development and evaluation. Start-up costs, based on a 750 student building, are approximately $167 per student. Once the program is operational, the cost drops to $100 per student.

Implications for Practice

In 1994 Congress passed *Goals 2000: Educate America Act.* Goal 7 states that by the year 2000, every school in the nation will be drug- and violence-free and offer a disciplined environment conducive to learning. *ACHIEVE* provides a means to achieve this goal for children and communities with the greatest need. Although *ACHIEVE* focuses on systems change in elementary schools, if the reductions in fighting continue, it shows potential for addressing *Healthy People 2000* objective 7-9 to reduce by 20 percent the incidence of physical fighting among adolescents aged 14-17.

Audience	
P	
K^3	✓
4^6	✓
M	
H	
K^{12}	
S	

Locale	
R	
U	✓
S	✓
M	

Level	
Cl	✓
B	✓
D	
Co	

Components	
C	
St	✓
Pe	✓
Pa	
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	✓
N	✓
B	✓

Drs. Howard M. Knoff and George M. Batsche
Institute for School Reform, Integrated Services and Child Mental Health and Educational Policy
School Psychology Program
The University of South Florida
FAO 100U, Room 268
Tampa, FL 33620-7750
PH: (813) 974-3246 / FAX: (813) 974-5814

ACHIEVE

	E	Design
✓	Q	

✓	I	Analysis
	G	
	B	
	D	
	C	
	M	

	QI	Data
✓	Qn	
	B	

	F	Type
	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

Two types of quasi-experimental designs tested the impact of *Project ACHIEVE*. One school conducted a pretest, on-going measures during three years of program implementation and a posttest after treatment. During the second year of the four year study, measures from a demographically-matched school served as a comparison for the program school. Both schools were part of a racially diverse school district with many children in pre-kindergarten through fifth grade coming from low-income households. The school district serves approximately 34,000 elementary students, 28 percent of whom are minorities and 48 percent of whom receive a free or reduced-priced lunch.

Data collection occurred on a monthly basis and included information on disciplinary actions, suspensions, attendance; the number of social skills training sessions held per week; the number of technical assistance sessions conducted; and the methods and frequency of home-school contacts. Data on grade retention, average student attendance, achievement scores, and satisfaction of teachers, parents and community as measured by a survey were collected annually. Dependent measures compared the program school to itself (baseline/post treatment) as well as to the comparison school. Indicators of effectiveness included student outcomes (e.g. referral to special education, placement in special education, disciplinary referrals to the principal, grade retention, achievement scores), teacher outcomes (e.g. teacher discipline referrals to the office), school outcomes (e.g. discipline, suspension/expulsion) and other outcomes (e.g. academic improvements of children whose parents were in the Parent Drop-In Program).

From baseline, the program school saw a 75 percent decrease in student referrals for special education assessment and the number of students placed in special education has declined from 6 percent to 2 percent of the student population after the third year of the program. The comparison school's special education placement rate was 7 percent. Over the years, the program school also experienced a 28 percent decline in total disciplinary referrals to the principal's office; a decline in student grade retentions from 6 percent to 1 percent in the third year; and a decline in out-of-school suspensions from nine incidents per 100 students to three incidents during the third year.

During the comparison year, 5 percent of students in the control school were suspended, compared to 3 percent at the project school. Other accomplishments included an increase in the number of students scoring above the 50th percentile on end-of-the-year achievement tests, especially for those involved at the youngest ages.

Teachers' perceptions of school climate improved but not significantly. Although academic achievement improved for students whose parents attended sessions at the Parent Drop-In Center, the difference from the comparison school was not statistically significant. All of the parents and 82 percent of teachers reported a significant decrease in the number and intensity of behavior problems. All parents who attended improved knowledge scores by an average of 10-20 percent on the course content; 82 percent of those parents agreed or agreed strongly that their relationship with their children improved; and 91 percent agreed or agreed strongly that they had better control of their children. The effects of the parent drop-in program were most significant in the area of social behavior. Twice as many of the program students as those in the comparison school improved in their home and school behavior.

Critique

Project ACHIEVE demonstrated that a school-wide reform program using comprehensive staff development and training can significantly enhance the social and academic behavior of students. The results are based on intense work and technical resources in one school building. Thus, it is unclear whether the successes observed in one school result from the project staff's presence or the project components themselves. Further, it is not known which components of the project are necessary for success. One measure used was fighting in school. No other measures examined health indicators, such as substance abuse, or long term effects on students' behaviors as they become adolescents.

Evaluation Contact

Drs. Howard M. Knoff and George M. Batsche
Institute for School Reform, Integrated Services and Child Mental Health and Educational Policy
School Psychology Program
The University of South Florida
FAO 100U, Room 268
Tampa, FL 33620-7750
PH: (813) 974-3246 / FAX: (813) 974-5814

Athletic Health Care System

Program Description

The *Athletic Health Care System* (*AHCS*), developed by Stephen Rice, MD, PhD, in conjunction with the Seattle Public Schools and the University of Washington Division of Sports Medicine, is a comprehensive program to prevent and manage injuries in interscholastic athletic activities. It has been approved by the National Diffusion Network of the U.S. Department of Education since 1983 and has been adopted by over 462 school districts in 27 states and territories.

The program enhances the health benefits of athletic activity for high school students who participate in interscholastic sports by reducing the risks and morbidity of injury. The goals of the program are to: 1) improve a school's injury prevention system; 2) improve the injury recognition and treatment system; 3) promote sound health practices by student-athletes; and 4) expose students to career opportunities in the athletic health care field.

Key elements of the program include: 1) assessing various health and safety aspects of the current athletic program including athletic facilities, equipment, central training room, staff training, emergency preparation, provision of health care services and record keeping; 2) educating a "health care team" comprised of all coaches, the school nurse, certified athletic trainers and student trainers in the principles and methods of basic sports medicine in the areas of injury prevention, emergency preparedness, injury recognition and treatment, supportive taping and rehabilitation; 3) organizing a central training room operated in part by student trainers under adult supervision and equipped to offer basic health care services; 4) creating an organizational risk-management system through use of checklists, guidelines, protocols and procedures; 5) establishing a record keeping system to document injuries and actions taken to safeguard against liability; and 6) evaluating the program on a regular basis.

This pioneering program has identified several important national trends: 1) injuries to female athletes occur more often than to male athletes; 2) fall sports have more injuries than spring sports; and 3) cross country running and soccer are among the upper tier of "high injury sports" along with football, wrestling and gymnastics.

Services Available

Materials to increase awareness, including literature and a video tape, are available at no cost. Schools adopting the program are required to attend a 30-hour, five-day course on site for the entire health team. In addition to a 300-page textbook, teaching methods include lectures, slide presentations, videos, anatomic models and demonstrations. One-third of the workshop is a hands-on laboratory experience.

Program materials, including all record-keeping forms, are provided to program adopters. In addition to the five-day workshop, an in-service program for program coordinators is available at the summer National Leadership Institute held in Seattle, Wash. Three-graduate credits are available from the University of Washington for the in-service program. Price breakdowns are available on request.

Implications for Practice

Nearly six million high school students participate in interscholastic sports annually. Nationally, an estimated two million injuries result in the loss of play each year. Although this number has been declining, the rate of major injuries is rising. Numerous studies in the past 20 years show that interscholastic athletes and their coaches possess little or no training in the basic principles of athletic health care. *AHCS* routinely incorporates the latest advances in sports medicine and offers the most comprehensive program available. *AHCS* challenges schools and communities to implement a sound risk management program in the best interests of schools and athletes.

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Pe	✓
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P	✓
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Se	✓

Emphasis	
K	✓
A	✓
N	✓
B	✓

Stephen G. Rice, MD, PhD
Project Director
Division of Sports Medicine
University of Washington
Box 354060
Seattle, WA 98195-4060
PH: (206) 543-6734 / FAX: (206) 543-6573

Athletic Health Care System

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	QI	Data
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Evidence of Program Effectiveness

Criteria for success were identified in four areas: training, emergency preparedness and pregame protocols; injury recognition and injury surveillance; and quality assurance. To measure the effectiveness of the training, a 72-item cognitive pre/posttest was developed. Kuder-Richardson-20 reliability coefficients of internal consistency range between .70 and .95. Since 1987, the test has been given to over 1,500 individuals with an average reliability of .84. Three categories of participants were identified: coaches, student trainers and health professionals (school nurses, physicians and athletic trainers). In every category pre/posttest knowledge gains have been consistently significant ($p<.001$).

To measure emergency preparedness and pregame protocols, an observation checklist of over 100 items was developed. Groups of certified athletic trainers determined face validity of the instrument for correctness and currency. Trained observers then used the checklists to monitor pre-event activity. Inter-rater reliability and ease of administration have been consistently high. Collected data were aggregated into two scores: emergency kit preparedness and a pre-event safety score. Clear differences were noted between treatment and control groups involving 250 observations. Nonparametric sum of rank testing (Mann-Whitney U) found a significant difference ($p<.002$) between treatment and control schools for emergency kit scores, as well as a significant difference ($p<.01$) for safety activities

To determine the effectiveness of training to recognize and report injury, a Daily Injury Report (DIR) was used. Control schools reported all injuries at a rate of 6.9 injuries per 1,000 athletic exposures compared to 17.3 injuries per 1,000 athletic exposures for the treatment schools. Treatment schools recognized many more minor injuries which resulted in shorter periods of limited participation. In 17 schools with at least eight years of program implementation, DIRs revealed a steady downward trend in the number of significant and major injuries leveling off at approximately 10 percent of all reported injuries, a significant difference from control reports.

Finally, qualitative measures, which followed an athlete from the moment of injury through all phases of recognition, transport, evaluation, treatment, rehabilitation and return to play, were used to assess the quality of actual care provided to injured athletes. Athletes were interviewed after the season using a structured, comprehensive questionnaire to obtain information about the injury and care rendered. Coaches, athletic trainers and student trainers were also interviewed to obtain additional and confirmatory data. The information was summarized into a structured format. In the latest extensive evaluation (1986-1989) using an experimental design with 70 cases (38 treatment cases in three schools and 32 control cases), six experts in sports medicine reviewed each case study using objective criteria for evaluation. Evaluators did not know whether the case came from a treatment or a control school. Eight-four percent of the treatment school cases received passing grades, while only 11 percent of control schools passed. In two of the three treatment schools, all passed.

Critique

The *AHCS* evaluation design is strong with attention to both process and outcome measures of both adults and students. Continuous refinement of measurement instruments has improved reliability over time, Multiple measures of the various facets of this program are an additional strength and increase confidence in the findings.

Evaluation Contact

Stephen G. Rice, MD, PhD
Project Director
Division of Sports Medicine
University of Washington
Box 354060
Seattle, WA 98195-4060
PH: (206) 543-6734 / FAX: (206) 543-6573

Be Proud! Be Responsible!

Program Description

Be Proud! Be Responsible! consists of six 50-minute lessons that provide information, motivation, and skills necessary to change adolescents' behaviors and reduce their risk of contracting HIV and other sexually transmitted diseases. *Be Proud! Be Responsible!*'s original target population was African-American male adolescents living in urban areas, although the current version works with male and female inner-city adolescents of various races. The curriculum has a strong inner-city and sense-of-community approach and examines how HIV and AIDS have affected inner-city communities. It suggests that protecting the community is one reason to change individual risky behaviors. *Be Proud! Be Responsible!* also stresses the role of sexual responsibility and accountability and the role of pride in making safer sexual choices. Because adolescents struggle with issues around self-esteem, self-respect and self-pride; *Be Proud! Be Responsible!* emphasizes that making responsible safer sexual choices can feel good. The Centers for Disease Control and Prevention identified *Be Proud! Be Responsible!* as a *Program that Works* in its *Research to Classroom* project that identifies risk reduction curricula with credible evidence of effectiveness.

In the original implementation, small groups of six to 12 adolescents participated in the curriculum. Subsequently, teachers have used the curriculum in classroom settings. The basis for the curriculum is social learning theory. Lessons address information about HIV and AIDS, vulnerability to HIV infection, attitudes and beliefs about participating in risky sexual behaviors, analyzing situations for risk, negotiation and refusal skills, correct use of a condom, self-efficacy and pride in oneself and one's community. Teaching activities include videos, small group discussions, games, condom demonstrations, and role playing. The curriculum helps participants recognize ways that faulty reasoning that leads to unsafe sexual activity can increase the risk of HIV infection and other negative consequences. It also helps students increase their comfort with condom use and decreases concerns about condoms reducing sexual enjoyment and spontaneity.

Services Available

The program includes a teacher's manual with background information, lesson plans, and masters needed for games and student activities plus videos. A package with the manual and video clips costs $95. Longer videos used in the curriculum, which are often available locally, are available at an additional cost. Training for educators acquainted with HIV prevention and adolescent sexuality requires 16 hours. Others will require 24 hours of training. Costs of training vary.

Implications for Practice

African Americans and Hispanics, especially those living in urban areas, have been disproportionately affected by HIV infection and AIDS. Fifty-two percent of AIDS cases in the United States are among African Americans or Hispanics, yet they represent only 23 percent of the population. African Americans account for over 50 percent of all the children diagnosed with AIDS. In 1994, the death rate from HIV infection was four times higher for African-American men than for white men and nine times higher for African-American women than for white women. *Youth Risks Behavior Survey* data has revealed that more African-American adolescents engage in sexual intercourse at younger ages than other teens in the United States. By seeking to reduce sexual activity and increase condom use among sexually-active, urban adolescents, *Be Proud! Be Responsible!* addresses several *Healthy People 2000* objectives (18.3, 18.4, 18.10, 19.9, 19.10, 19.11).

Audience	P	
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Level	Cl	✓
	B	
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Components	C	✓
	St	
	Pe	
	Pa	
	M	
	P	
	Sk	✓
	Se	
Emphasis	K	✓
	A	✓
	N	
	B	✓

for program information:
Loretta Sweet Jemmott, Ph.D.
University of Pennsylvania
School of Nursing
420 Guardian Drive, Suite 309
Philadelphia, PA 19104-6096
PH: (215)898-6373
FAX: (215)573-9193

to order materials:
Select Media
PH: (212) 732-4437

to arrange for training:
Staff Development Office
Rocky Mountain Center for
Health Promotion and Education
PH: (303) 239-6494

Be Proud! Be Responsible!

✓	E	Design
	Q	

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	D	
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	QI	Data
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Evidence of Effectiveness

A study started in 1988 supported by the American Foundation for AIDS Research and the National Institute of Child Health and Human Development recruited 157 inner-city, African-American males. Forty-four percent of the participants were outpatients at a clinic, 32 percent were high school students, and 24 percent were from a YMCA. Their ages ranged from 12 to 19 with a mean age of 14.6. Ninety-seven percent concurrently attended school. At baseline, 79 percent reported using condoms, but only 30 percent always used them. Their primary risk for HIV infection was heterosexual intercourse. Participants received pay for attending and returning the three-month follow-up questionnaire (completed by 96 percent of participants).

The six-hour program took place on one Saturday in a local school. When participants arrived, they completed preprogram questionnaires that included items about HIV risk-associated sexual behaviors, intentions to engage in risky sexual behaviors, attitudes toward risky sexual behaviors, knowledge about HIV and AIDS and career-related information. As students took the pre-test, researchers stratified them by age and randomly assigned them to either the program or a control intervention that involved instruction on career opportunities. Participants completed post-test questionnaires at the conclusion of the program and again three months later. Over several months, 27 small groups (14 program and 13 control) participated in the study. Facilitators were African-American men and women who had experience working with youth, knowledge of HIV and AIDS, at least a four-year college degree and six hours of training on the program.

Immediately after the program, youth exposed to *Be Proud! Be Responsible!* had greater knowledge about HIV and AIDS, less favorable attitudes toward risky sexual behaviors, and weaker intentions to engage in such behaviors than did the controls. Knowledge gains were greatest in groups led by a male facilitator. At the three-month follow-up, *Be Proud! Be Responsible!* participants scored higher than the controls on knowledge and behavioral intentions to refrain from risky behaviors and they reported engaging in less risky sexual behaviors. The reductions in risky behaviors were greatest in groups led by female facilitators.

Participants in the *Be Proud! Be Responsible!* group were no more likely than the control to practice abstinence, but they did report having intercourse on fewer days, with fewer women, and with fewer women involved with other men. They also reported using condoms more often and reductions in anal intercourse.

Critique

The robustness of the study design, including random assignment to a comparable but not overlapping control makes the relatively small sample size acceptable. Paying participants probably contributed to the 96 percent retention rate for the three-month follow up. It could also have biased self-reports of behaviors, although the researchers used several measures intended to limit self-report bias. Recruitment of volunteers to participate occurred in various urban community and school settings, but the vast majority of participants attended school, reported using no injectable drugs or sharing needles and none reported homosexual or bisexual activities. Participants, thus probably did not represent urban youth at the highest risk for HIV infection, although all participants reported sexual experience at pretest. The program reduced the participation of urban African-American males in risky sexual behaviors and increased condom use, but did not promote abstinence.

Evaluation Contact

John B. Jemmott III, PhD
Princeton University
Department of Psychology
Washington Road
1S1 Green Hall
Princeton, NJ 08544-1010
PH: (609) 258-4442 / FAX: (609) 258-1113

Becoming A Responsible Teen

Program Description

Becoming a Responsible Teen (*BART*) is an HIV/AIDS prevention education curriculum based on social learning theory and the IMB (information, motivation, behavioral skills) risk reduction model. Developed in conjunction with a local advisory panel of teenagers, the program combines information with skills training on correct condom use, sexual assertiveness, refusal skills, self-management, problem solving and risk assessment.

The program consists of eight sessions that last 90 to 120 minutes each. Topics include information about HIV and AIDS, sexual decisions and values, condom use, communication in relationships, strategies for avoiding high risk situations, developing creative solutions to problems and providing peer support for responsible actions. Activities include a panel presentation by HIV-positive youth, group discussions and role-plays created by teens. The curriculum includes two culturally appropriate videos. Activities encourage teens not only to protect themselves, but also to spread the word among their friends. Out-of-class assignments include use of the skills learned, reporting back at the next meeting.

The Centers for Disease Control and Prevention reviewed *BART* for its *Research to Classroom Project* and found it to have credible evidence of effectiveness in modifying behavior. As of 1997, *BART* was one of only four HIV/AIDS risk reduction programs CDC had identified as having such evidence.

Services Available

The Education Development Center can identify trainers to conduct the recommended two and a half to three days of training for group leaders. ETR Associates offers a curriculum guide for *BART* that includes session outlines, instructions for group leaders, handouts for duplication, consent forms, and general considerations for setting up the program.

Implications for Practice

The incidence of sexually transmitted diseases (STDs) serves as a reasonable indicator of the potential risk of adolescent-acquired HIV infection. Rates of gonorrhea infection have generally increased or remained stable among adolescents aged 15 to 19 in the last decade and adolescents account for almost a third of all STD cases. Low-income, minority youth living in cities are at greater risk than the general population for infection with HIV and other STDs due to greater concentrations of these diseases in urban areas. Therefore, providing HIV and STD risk-reduction interventions to low income urban adolescents is a public health priority. Sections 18 and 19 of *Healthy People 2000* identify several objectives related to preventing infection with HIV and other STDs. Information alone is not sufficient to motivate behavior change, particularly in light of adolescents' feeling of invincibility. *BART* addresses participants' informational needs, motivational influences, and behavior within a well-documented social learning framework. It provides developmentally and culturally-appropriate avenues to address the particular concerns of urban, low-income, minority youth.

Audience	
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Pe	
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Emphasis	
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N	✓
B	✓

for trainers:
National Training Partnership
Education Development Center
872 West Ford Road
Carlisle, MA 01741
PH: (800) 225-4276

for materials:
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
PH: (800) 321-4407

Becoming A Responsible Teen

✓	E	Design
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Evidence of Program Effectiveness

The evaluation study was conducted in a medium-sized southern city at a community health center that serves predominantly low-income, African-American patients. After receiving informed consent, interviewers conducted individual assessments of adolescents in a private conference room at the center. Eligible participants were youth between the ages of 14-18 who had no symptoms of HIV infection.

Two hundred forty-six adolescents (28 percent male) were randomly assigned either to an educational program (control group) or to the eight-week program intervention. At baseline, 42 percent of the comparison students and 36 percent of the participants reported engaging in sexual intercourse in the eight weeks prior to recruitment. Thirteen percent of the sample had at least one child. Subjects received $5 per hour for each session they attended. They also received a t-shirt for attending all sessions.

At pretest, the two groups showed no significant differences in risk behaviors. Male adolescents, however, were significantly less positive than females in their attitudes toward condoms and response efficacy and higher in the number of lifetime sexual partners. The control group received one two-hour educational session that was developmentally and culturally appropriate. The session consisted of information interspersed with games, group discussion and other activities typical of many classroom-based curricula. Program participants attended eight weekly sessions that included behavioral skills training. The first session was the same for both groups. In addition to factual information, youth in the *BART* program participated in activities to build skills in correct condom use, assertive communication, refusal, sharing information with others, self-management, problem solving and risk recognition. Group sizes ranged from five to 15.

Interviewers individually reassessed participants in both the control and *BART* interventions two, six and 12 months after the program ended using the same measures as the pre-intervention. Of the original 246 participants, 91.5 percent completed the year follow up. There were no significant differences in mean age, education or instrumental measures among those lost to attrition, usually due to a family move. Measures consisted of self-reports of knowledge, attitude and behaviors and trained observers' assessments of performance in simulated role-plays developed and validated by youth as difficult but real social situations. The self-report tests were modifications of standardized instruments. Reliability measures ranged from .75-.80.

Participants in *BART* were significantly more skillful than those who received only the two-hour session at handling coercive situations and providing information to peers. They were more likely to acknowledge the partner's wish in a positive way while providing a rationale for their refusal, stressing the need for safety and recommending safer alternatives ($p<.0005$). Interestingly, *BART* produced significantly greater increases in knowledge and the difference was sustained across the year follow-up period despite the fact that both groups received the same information. At the year follow up, 42.5 percent of the comparison group reported being sexually active compared to 27 percent of the *BART* participants. In addition, those who were sexually active and who participated in *BART* reported significantly fewer sex partners over the year period. Females who participated in *BART* were significantly less likely than the controls to engage in unprotected intercourse and were more likely to use condoms regularly over the year period. Males who participated in *BART* were significantly more likely than the controls to use condoms immediately after the program and for the first six months however these differences disappeared by the year follow up.

Critique

This was a well-designed, rigorous evaluation that produced statistically and clinically meaningful results. In addition, it was well received by the participants and their families. The findings confirmed that explicit sexual education and skills training can lower rates of sexual activity among previously active youth and deter the onset of sexual activity for youth who are abstinent at program entry.

Evaluation Contact

Janet S. St. Lawrence
Division of STD Prevention
Centers for Disease Control and Prevention
4770 Buford Hwy., NE
Atlanta, GA 30341
PH: (404) 639-8376

California's 5 A Day Power Play

Program Description

The California Children's *5 A Day Power Play!* Campaign is a statewide initiative of the California 5 A Day For Better Health! Campaign established in 1992. The "Better Health" campaign is a public/ private partnership involving the California Departments of Education and Health Services, the American Cancer Society (California division), the National Cancer Institute and the produce industry. Over a period of 10 weeks it uses local media and social marketing techniques based on social learning theory and resiliency theory to raise awareness of the importance of eating fruits and vegetables. It engages fourth- and fifth-grade children and their parents in a variety of promotional activities in various settings including schools, community youth organizations, supermarkets and farmers' markets.

Teachers select the *5 A Day Power Play!* classroom activities from among 65 included in the Resource Kit. The Resource Kit is organized into six "power" components: *Classroom Power* includes activities for a large group; *Student Power* activities are done independently at school or at home; *Family Power* encourages family interaction; *Cafeteria Power* encourages children to select a fruit and vegetable at breakfast and lunch and helps make the cafeteria a "living laboratory;" *School Power* helps bond the student to the school; and *Community Power* encourages students to interact with their community safely and confidently. Within each Power component, activities begin with knowledge and awareness, move through skill building and end with application. Teachers and school food service personnel implement all activities. Classroom activities integrate into science, mathematics and language arts, as well as health.

Services Available

A *5 A Day Power Play!* School Idea and Resource Kits are available in English and in Spanish for $36. Stickers, posters and miniposters are also available. Quantity discounts apply.

Implications for Practice

Cancer is the leading cause of death for adults aged 65 or younger. Cancer is not one disease but a constellation of more than 100 different diseases, each characterized by the uncontrolled growth and spread of abnormal cells. There are many factors that contribute to this long-term disease process. More than a third of all cancer deaths are linked to tobacco use. In addition, *Healthy People 2000* has identified two diet-related objectives: 16.7 seeks to reduce dietary fat and 16.8 seeks to increase the consumption of fruits, vegetables and grains. Adults who eat five servings or more of fruits and vegetables have about half the risk of most major cancers compared to adults who eat two servings or fewer. In addition, the increased fruits and vegetables eating pattern is protective against heart disease and stroke, and reduced calorie intake and weight gain.

The habit of eating fruits and vegetables begins in childhood and continues into adulthood. A recent study from the National Cancer Institute found that only one in five American children consumed the recommended five servings. A U.S. Department of Agriculture study recently concluded that fruits and vegetables are the least consumed of the five food groups and that fruit and vegetable intake by youth is falling. The *5 A Day Power Play!* compliments national efforts to encourage consumers to eat more fruits and vegetables daily by providing experiential activities for children in the school classroom.

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Tanya Garbolino
Nutrition and Cancer Prevention Program
California Department of Health Services
601 North 7th Street, MS-65
P.O. Box 942732
Sacramento, CA 94234-7340
PH: (916) 327-2918 / FAX: (916) 322-1532

California's 5 A Day Power Play

Design: [ ] E [✓] Q

Analysis: [ ] I [ ] G [ ] B [ ] D [✓] C [ ] M

Data: [ ] QI [✓] Qn [ ] B

Type: [ ] F [ ] S [✓] O [ ] P

Evidence of Program Effectiveness

The evaluation took place during an eight week period from February to June 1995 and involved 3,966 children in fourth and fifth grade in 49 schools in four school districts in three geographically distinct communities. Over 70 percent of the children were Hispanic. Attrition was 5 percent. One community served as the control, one received the activities designed to be implemented in school only and the third received the school and community activities.

One hundred fifty-one teachers in the four school districts received training in data collection. The children in all three communities completed simplified 24-hour food diaries and questionnaires before and after the intervention, resulting in 2,684 matched sets of food diaries and questionnaires. A pre/post-design measured changes in diet, knowledge, attitudes, norms and behaviors. Intermediate variables included having a nutrition lesson in school, participation in the school lunch program, factors in the child's environment, policies of participating organizations, and the intent of the school to teach, repeat or increase the offering of the *5 A Day Power Play!* campaign activities in future years. At baseline, only three of the 36 teachers interviewed reported teaching much nutrition education during the previous year. They cited several barriers including lack of materials, funds and training. Additional measures monitored choice of fruits and vegetables, preparation skills and intake of fruits and vegetables. Fruit and vegetable intake at baseline ranged from 2.6 - 2.9 servings at all three sites and was not significantly different. Approximately 10 to 15 percent of children did not eat any fruits and vegetables in all three sites. There were no differences in consumption among the three ethnic groups represented (Anglo, Latino, Southeast Asian). Children who reported daily participation in the school lunch program did not differ in fruit and vegetable consumption from children who did not participate daily.

The evaluation found that fruit and vegetable intake rose to 2.9 servings in schools offering *5 A Day Power Play!* activities and to 3.4 daily servings when both the school and community participated. Consumption of fruits and vegetables dropped to 2.3 servings in the comparison community. The proportion of children who consumed five servings or more daily increased significantly in both program sites, with the school and community site being higher. The proportion dropped significantly in the comparison community. Children in both intervention groups significantly increased their belief that they needed to eat five servings of fruits and vegetables for good health. Children who had planted a garden and eaten its produce were significantly more likely to eat fruits and vegetables than children who did not have that experience.

Critique

5 A Day Power Play! is practical, targets an important health behavior and addresses attitudes, knowledge and beliefs about eating fruits and vegetables that appear to positively influence behavior change. Ninety percent of the 15 teachers interviewed at follow-up stated that they would be willing to use the activities in the future. The evaluation illustrated the value of involving the community in nutrition education efforts to reinforce messages at school. The published study provided limited information regarding evaluation details, including no measures of reliability and validity of the instruments, inferential statistics and details of how food intake was monitored.

Evaluation Contact

Jennifer Gregson
Nutrition and Cancer Prevention Program
California Department of Health Services
601 North 7th Street, MS-65
P.O. Box 942732
Sacramento, CA 94234-7340
PH: (916) 323-0594 / FAX: (916) 322-1532

CATCH PE

Program Description

The *Child and Adolescent Trial for Cardiovascular Health (CATCH)* program, is designed to motivate students in grades 3-5 to adopt heart healthy behaviors. Funded by the National Heart, Lung and Blood Institute (NHLBI), *CATCH* has several components: heart health education curriculum for the third, fourth and fifth grades; family involvement activities; *EAT SMART*, a food service program; and *CATCH PE*, a physical education program.

The third-grade curriculum, *Hearty Heart and Friends,* is a five-week, 15-lesson unit on healthy eating. Each lesson is 30 minutes. The fourth-grade curriculum, *GO for Health*, is a 24-session, 12-week curriculum focusing on nutrition and physical activity. It introduces GO, SLOW, and WHOA foods and activities to teach children to make healthier choices. Each session is 40 minutes. The fifth-grade curriculum, *Breaking through Barriers*, is a 16-session, eight-week curriculum that includes problem solving around food choices and physical activity. A four-session, four-week curriculum on tobacco use prevention compliments the physical activity and nutrition lessons. The heart healthy curricula provide a foundation of information and skills which are extended and reinforced by *CATCH PE.*

CATCH PE encourages moderate to vigorous activity for at least 40 percent of physical education class time for a minimum of three sessions per week totaling 90 minutes. The curriculum contains recommendations for class structure, management and safety as well as sample lesson plans. An Activity Box contains suggested physical education activities on index cards that use color coding to identify warm up exercises, fitness-focused skills, sports skills and cool down activities. Three videos with adults and children working together supplement the curriculum: *Fitness Fever*, a 43-minute workout tape; *Benchin' It*, a 38-minute bench aerobic workout; and *More Benchin' It*, a 76-minute tape with six, short segments of bench aerobics that progress from simple to more complex.

CATCH PE promotes participation in and enjoyment of physical activities. The curriculum's flexibility encourages activity during recess, as part of extracurricular activities or with family and friends. In order to be successful, the program requires 90 minutes of total class time with a minimum of three sessions per week and a high degree of commitment by the staff plus two days of staff development per year.

Services Available

The *CATCH PE* curriculum (#55-725) costs $60 and includes a guidebook and activity box. Three videos cost $12 each. *Heart Healthy* curricula for grades 3-5, range in price from $20 to $50, with a 10 percent discount for orders of three or more.

Implication for Practice

Regular physical activity reduces the risk of coronary heart disease, hypertension, diabetes, cancer and mental illness. Less than 10 percent of Americans engage in regular physical activity and the prevalence of inactivity increases with age beginning in adolescence. *Healthy People 2000* objective 1.4 calls for increasing to at least 20 percent the proportion of individuals over age 6 who engage in activities that promote the development of cardiorespiratory health. Objective 1.6 calls for increasing to at least 40 percent the proportion of individuals who perform physical activities that enhance and maintain muscular strength, endurance and flexibility. Objectives 1.8 and 1.9 address the need for school-based physical education that encourages students to practice lifetime fitness activities. The *Healthy People 2000 Midcourse Review and 1995 Revisions* notes that adults are making some progress toward achieving Objectives 1.4 and 1.6, but adolescents are losing ground. An increasing percentage of children and adolescents are overweight. In 1995 fewer schools offered physical education three times a week than in 1990. The *CATCH PE* and *Healthy Heart* curriculum are inexpensive, effective and well-received by students and instructors.

Audience	
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Emphasis	
K	✓
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B	✓

to order materials:
Information Center
National Heart
Lung and Blood Institute
P.O. Box 30105
Bethesda, MD 20824-0105
PH: (301) 251-1222 / FAX: (301) 251-1223.

for training:
Todd Galati
San Diego, CA
PH: (619) 685-4817

CATCH PE

✓	E	Design
	Q	

	I	Analysis
✓	G	
	B	
	D	
	C	
✓	M	

	QI	Data
	Qn	
✓	B	

	F	Type
	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

The evaluation of *CATCH PE* was part of the overall *CATCH* evaluation study that involved 96 public schools from 12 school districts in Texas, Louisiana, California and Minnesota. Schools were randomly assigned to receive the program (56 schools; 14 per field site) or serve as comparison schools (40 schools; 10 per field site). Further randomization divided the program group into equal subgroups: half the program schools received *EAT SMART, CATCH PE* and the heart health curricula for grades 3-5; the other group received the same program plus a family-based program. The study followed a total of 5,106 children, 69.1 percent White, 14.1 percent Hispanic, 13.0 percent African American, and 3.8 percent other who were in the third grade at baseline for three years (1991-94).

CATCH PE 's evaluation used the System for Observing Fitness Instruction Time (SOFIT). This valid and reliable measure involves direct and systematic observation of both students and teachers during physical education classes to assess the quality and quantity of activity. Trained assessors visited every school twice a semester for six semesters and completed a Physical Activity Record of Classes (PARC) to record the frequency and duration of physical activity. In addition, the Self Administered Physical Activity Checklist (SAPAC) assessed type, duration, and intensity of selected leisure time activities.

Findings revealed that teachers implemented over 80 percent of *CATCH PE* activities. The average length of physical education classes did not change, but intensity increased significantly. Students who received the program reported 58.6 minutes of vigorous activity compared to 46.5 minutes at comparison schools ($p < .003$), surpassing the *Healthy People 2000* goals. At the end of three years, students in program schools increased the distance run by 100 yards in the nine-minute distance run compared to 84 yards by students in the comparison schools, although this difference was not statistically significant.

Physiologic measures such as students' blood pressure and serum cholesterol levels did not differ significantly by condition. Follow-up participation did not differ by gender or involvement in the program versus control. However, African-American students and those from California dropped out at a higher rate.

Critique

CATCH, to date, is the largest and most rigorous school health program implemented and evaluated in the nation. It demonstrated that schools with diverse populations in four areas of the country can implement a multifaceted program involving school food service, physical education, classroom curricula and family involvement. Limitations of the study included low participation rates in physiologic measures (60.4 percent) due to the need to draw blood samples and limited time for instruction and staff development. The study did not distinguish between the impact of *CATCH PE* alone, but only as part of a school-wide program that included health instruction and food service modifications. Long term follow-up of the students who participated in *CATCH* could yield valuable information about the maintenance of positive lifestyle habits.

Evaluation Contact

Russell V. Luepker, MD
Division of Epidemiology
University of Minnesota
School of Public Health
Minneapolis, MN 55454
PH: (612)624-1818 / FAX: (612)624-0315

Child Development Project

Program Description

The *Child Development Project* (*CDP*) is a multi-year, comprehensive elementary school program to reduce risk and bolster protective factors among children. Established in 1980, *CDP* draws on research and theory on socialization, learning and motivation and pro-social development. The program helps schools become caring communities of learners — environments with supportive relationships, a sense of common purpose, commitment to social, ethical and intellectual learning, and meaningful and engaging curriculum. Such a school involves students in decision making and in the intellectual and social life of the classroom and school. This is a "systems-level" program aimed at the school and the student peer group, not just the individual student.

Five strategies comprise the core of the program. The first requires building stable, warm and supportive relationships between teachers, administrators and students. The second involves simultaneous attention to social, ethical and intellectual learning. The third is teaching for understanding. The fourth provides challenging, learner-centered curricula that are relevant to children's lives. The final strategy fosters students' intrinsic motivation to learn and to uphold the values of their community. *CDP* utilizes a combination of classroom practices, whole school activities and linkages between home and school to realize these strategies. Classroom activities include 1) cooperative learning exercises that involve children in problem-solving, dialogue, and discovery so that they construct their own understanding of new information; 2) a values-rich, literature-based reading and language arts program, including *Reading, Thinking and Caring* (Grades K-3) and *Reading for Real* (Grades 4-8); and 3) "developmental discipline" techniques that give students appropriate levels of responsibility for classroom management and decision-making. Classroom and school-wide community-building activities involve parents in *Homeside Activities* that promote greater parental involvement in their child's learning and strengthen the child-parent, home-school bonds.

The *CDP* program is a rigorous and demanding program that requires sustained school-wide support and involvement by teachers, staff, students and parents - it is not a "quick fix." Successful implementation demands a fundamental shift of the school culture and a deep change in most teachers' instructional and classroom management practices, a change that is often stressful. Conditions and attitudes that enhance the likelihood of success include a shared vision of education; district central office leadership and support; effective and involved principals; sustained, mutual, collegial support; involvement of the whole school staff, not just teachers; openness to new ideas and institutional structures that support ongoing, collaborative adult learning and broad measures of success. The program developers estimate that high quality implementation requires a minimum of three years.

Audience	
P	
K[3]	✓
4[6]	✓
M	
H	
K[12]	
S	

Locale	
R	
U	
S	
M	✓

Services Available

CDP utilizes trade books, curriculum guides and manuals, and other assorted materials. The staff development program takes three years to complete and includes an orientation, summer institutes, site visits by the *CDP* staff, individual coaching, seminars and workshops. Much of the cost is often grant-supported.

Level	
Cl	✓
B	✓
D	✓
Co	✓

Implications for Practice

Drug use, delinquency and other problem behaviors result from complex interactions between individuals and the environment, yet few schools pay attention to the deliberate structuring of the school environment or the social and ethical character development of students. The *CDP* recognizes that schools play a major role in the socialization of children, which includes reasoning and developing values about right and wrong, treatment of others and how to live one's life. Consequently, the *CDP* challenges parents and everyone in the school system to create an environment that is conducive to the development of the whole child.

Components	
C	✓
St	✓
Pe	
Pa	✓
M	
P	
Sk	
Se	

Emphasis	
K	
A	✓
N	✓
B	✓

Sylvia Kendzior
Director of Child Development Project Staff Development
Developmental Studies Center
2000 Embarcadero, Suite 305
Oakland, CA 94606-5300
PH: (510) 533-0213 / FAX: (510) 464-3670

Child Development Project

	E	Design
✓	Q	
	I	Analysis
	G	
✓	B	
	D	
	C	
	M	
	QI	Data
	Qn	
✓	B	
✓	F	Type
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✓	O	
✓	P	

Evidence of Program Effectiveness

With support from multiple federal and foundation grants, the Developmental Studies Center in Oakland, California conducted a longitudinal, quasi-experimental study that examined the impact of the *CDP* on students' involvement in drug use and delinquent behaviors. The study included 24 elementary schools from six school districts throughout the United States. Of the schools, 12 were on the West Coast, four in the South, four in the southeast and four in the northeast. The districts represented both large and small urban, suburban and rural areas. In each district, two schools received the program and two served as controls. The Developmental Studies Center (DSC) staff trained district leaders during the 1991-92 school year. Those leaders introduced the program to school staff during the 1992-93 year. DSC staff continued helping the leadership team with implementation through the 1994-95 school year.

Measures included structured classroom observations four times a year for two years, annual teacher questionnaires and surveys of students in the top three grades in each school (either grades 3-5 or 4-6). Beginning in the 1991-92 school year, evaluators surveyed successive cohorts of students in the top grade of each school (either five or six) to measure drug use and other delinquent behaviors. Students participated in the survey only with parental consent (obtained for 77 percent of students at baseline, 82 percent in Year 1 and 80 percent in Year 2). The delinquent behaviors measured were running away from home, skipping school, property damage, theft, carrying a weapon, threats, actually hurting someone, taking a car without the owner's permission and being involved in a gang fight. The annual teachers' surveys addressed school practices and climate as well as teacher attitudes and beliefs.

Univariate analysis showed that between 1992 and 1994 alcohol use declined significantly ($p < .02$) in the demonstration schools compared with the comparison schools. Marijuana use showed a similar but not statistically different from control decline. Tobacco use declined in program and control schools.

No significant differences appeared between program and control groups for any other delinquent behaviors. A secondary analysis considered levels of implementation and ranked the 12 demonstration schools as high, moderate or low implementation based on multiple measures of teachers and school climate. Program effects were strongest for students in the schools with the highest level of implementation. In addition to changes in drug use, students at the high-implementation schools showed significantly lower rates of skipping school, carrying weapons and vehicle theft than did comparison students in Year 2.

An additional analysis examined the generality of the theoretical model across socioeconomic differences. Prior to program implementation, student poverty level was negatively correlated with students' sense of school community and with most student outcome variables. Multiple groups structural equation modeling found that the predicted relationships between teacher practices, student classroom behavior and sense of community held for both high- and low-poverty students and that the strength and pattern of relationships were virtually identical in both groups.

Critique

The interim findings appear quite promising, although more definitive conclusions will be available when the study concludes. Limitations include no measures of family involvement or of within-school variations and no analyses of differential program effects based on students' gender, ethnicity and age. The findings thus far support that schools in a variety of settings can implement the *Child Development Program* and that when adequately implemented *CDP* increases students' perceptions of the school as a caring community. When schools achieve this sense of community, student drug use and delinquent behavior decreases.

Evaluation Contact

Dr. Victor Battistich
Deputy Director of Research
Developmental Studies Center
2000 Embaracadero, Suite 305
Oakland, CA 94606-5300
PH: (510) 533-0123 / FAX: (510) 464-3670

Children of Divorce

Program Description

The *Children of Divorce Intervention Program* (*CODIP*), developed in 1982 by JoAnne Pedro-Carroll, PhD, as part of the Primary Mental Health Project, is a school-based program that helps children cope with emotional and behavioral difficulties resulting from divorce. A central tenet of the program is that timely interventions for children living through a divorce can offer important short and long term benefits. *CODIP*'s goals are to create a supportive group environment in which children can share experiences freely and establish common bonds, clarify misconceptions about divorce and enhance their capacity to cope.

The program utilizes a group format and flexible intervention approach. Group facilitators are usually a male and female team selected for their interest, skills and sensitivity, as well as training. Leaders are school psychologists, social workers, nurses, teachers, guidance counselors, principals or mental health professionals. *CODIP* meetings are scheduled during the school day in an area that offers privacy. Decisions about group size, session length and program duration depend on the group. For example, weekly one-hour sessions for six-to-eight children work well with older youth and with younger children, 45-minute weekly sessions with groups of four to five children seem ideal.

Because children's reactions to divorce vary by developmental level, *CODIP* has different curricula. For children in grades K-3, the curricula offer support and skill-building in appealing, action-oriented contexts that capture young children's active involvement. Puppet play, interactive games, doll play, books and discussion convey program concepts and help children express their feelings. Fourth- to sixth-grade children often respond to divorce with anger and resentment and feel embarrassed or different than peers. The program addresses these feelings in a supportive environment. Activities include filmstrips, discussions, role-plays, modeling by group leaders and a group newsletter that offers a forum for creative writing, drawing, poetry and humor. Students take turns as members of a "panel of experts" on divorce and field questions from other group members. The curriculum for seventh and eighth grade teaches effective communication, social problem-solving and anger-control skills using group exercises, role plays and a video.

The program promotes realistic hopes for future relationships and building trust. Thus, some exercises pivot around taking small risks in a safe setting.

Although initially created for children in fourth to sixth grade in suburban schools, the program has expanded for use in grades K-8 and with children in urban settings. Schools throughout the United States and other countries, including Canada, New Zealand and Australia have implemented *CODIP*. In 1991, the program received the National Mental Health Association's Lela Rowland Award for preventive services.

Services Available

The K-1 curriculum of 12 lessons costs $40 and includes a program manual and a game; the second- and third-grade curriculum has 15 lessons and includes a program manual and game for $45. The fourth- to sixth-grade program (12 lessons) includes a manual and costs $40. A manual for seventh and eighth grades will be available in mid-1998. Training costs vary according to need.

Implications for Practice

Each year, more than a million couples in the United States end their marriages. Divorce is linked to a variety of social adjustment problems in children including delinquency, low self-esteem and hostility. *Healthy People 2000* objectives 6.8 and 6.9 call for individuals who are experiencing emotional and stressful events to seek help. School-based programs such as CODIP, which provide a strong support system and teach coping skills, can help alleviate children's negative reactions to divorce and prevent long-term trauma for children of divorce.

Audience		
	P	
	K[3]	✓
	4[6]	✓
	M	✓
	H	
	K[12]	
	S	

Locale		
	R	
	U	
	S	
	M	✓

Level		
	Cl	
	B	✓
	D	
	Co	

Components		
	C	✓
	St	✓
	Pe	
	Pa	✓
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	✓
	N	
	B	✓

(for program information)
Geri Cone
Primary Mental Health Project
685 South Ave.
Rochester, NY 14620-2290
PH: (716)262-2920

(for training)
JoAnne Pedro-Carroll, PhD
Director
Children of Divorce
Intervention Program
575 Mt. Hope Ave.
Rochester, NY 14620-2290
PH: (716)273-5957
FAX: (716)232-6350

Children of Divorce

	E	Design
✓	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
✓	Qn	
	B	
	F	Type
	S	
✓	O	
	P	

Evidence of Program Effectiveness

Since its inception in 1982, *CODIP* has undergone extensive evaluation. A 1992 study evaluated the efficacy of a 14-week secondary prevention program for fourth- to sixth-grade urban children of divorce.

A program announcement in school newsletters and direct contacts with parents by school mental health professionals recruited children for the *CODIP* groups. Inclusion criteria were having parents who were divorced or separated, not currently receiving mental health services and having no severe emotional problems. Some participants had experienced multiple stressors such as change in schools and residence, economic pressures, and minimal contact with fathers. Letters to parents invited their children to participate in a study of child development and family life. The study sample included 188 children from nine schools (57 CODIP participants, 38 non-program divorce controls, 93 comparison from never-divorced families), matched by grade and gender. One hundred ten boys and 78 girls participated, 44 percent of whom were from minority backgrounds. On average, 18 percent of the families in these schools had incomes at poverty level or below. Some modifications were made to the program to accurately reflect the cultures and realities of the participants.

Pretests of children, parents and teachers occurred in small groups two to three weeks before the program began using six measures of adjustment. Posttests used the same measures two to three weeks after the program ended. The 16-item Children's Family Adjustment Scale assessed children's feelings about their family ("I feel very sad when I think about my family"), themselves ("My feelings are OK to have") and support sources ("I talk with my mother or father about how I feel"). Only children in the divorce groups completed the Children's Attitudes and Self Perceptions scale that assessed attitudes and perceptions about divorce ("It's OK for me to talk with my friends about my parents' separation"). In addition, children completed an anxiety inventory and parents filled out a 20-item evaluation form concerning their views of children's feelings ("Keeps feelings to him/herself"), concerns ("Worries about the family") and behavior ("Gets into trouble when s/he is angry"). Classroom teachers rated all children on items related to problem behaviors and social competence. Group leaders assessed students using a 20-item evaluation form.

Ten items assessed emotional and behavior problems and 10 measured adaptive competencies. Reliability of the six instruments ranged from .65 to .92 and they demonstrated validity.

CODIP benefitted children's adjustment in several ways. Program children improved significantly more than the other groups on all child and parent adjustment measures, in their understanding of divorce-related events and ability to handle changing family situations. They also evidenced less anxiety and fewer negative attributions about themselves and their families. Parent reports confirmed these self-views. Some parents noted that children showed better impulse control, problem-solving and nonviolent conflict resolution. Both parents and children reported that participants had more realistic perceptions of situations they could and could not control. The program helped children identify unsolvable problems beyond their control, disengage from them and redirect their energies into activities within their control.

A two-year follow-up study conducted in 1996 involved teachers who were blind to the children's initial group status. *CODIP* children had significantly fewer school problems and more competencies than comparison. Parent interview data confirmed the effects over time. Other benefits included fewer trips to the school health office and gains in friendship formation, anger control and effective communication.

Critique

Given the significant life stress children of divorce experience, the data suggest that *CODIP* can ameliorate some potentially stressful problems associated with divorce and provide children with skills that help them cope with divorce. Longer follow-up studies could confirm the durability of the short-term gains found.

Evaluation Contact

JoAnne Pedro-Carroll, PhD
Director
Children of Divorce Intervention Program
575 Mt. Hope Ave.
Rochester, NY 14620-2290
PH: (716)273-5957 / FAX: (716)232-6350

Coca-Cola Valued Youth Program

Program Description

The *Coca-Cola Valued Youth Program* (*VYP*) is a tutoring program to prevent school dropout among non English-proficient students. Developed in 1984 by the Intercultural Development Research Association (IDRA) and funded by Coca-Cola USA, it was designed in collaboration with schools in San Antonio, TX. The goals of *VYP* are to reduce dropout rates, enhance students' basic academic skills, strengthen students' perception of self and school, decrease student truancy, reduce student disciplinary referrals and form school-home-community partnerships to increase the level of support available to students.

The program pairs academically floundering, at-risk teenagers with younger children and turns perceived liabilities into strengths. The students participating have ranged in age from 11 to 21 with the median age being 14 (eighth grade). Most of the tutors and mentors are Hispanic (80 percent) or African American, although the program is open to students of all racial and ethnic backgrounds. Admittance depends only on students' having one or more risk characteristics, such as poor academic performance, high rates of absenteeism or disciplinary referrals. Mentors attend a weekly training seminar to develop and improve their tutoring skills. After an initial observation period in an elementary classroom, tutors begin tutoring a minimum of four hours per week, for which they receive minimum wage pay. They work with children in a one-to-three ratio and adhere to the employee guidelines of the host school. Each tutor is treated as an adult, with adult responsibilities, but has teacher supervision and support. In addition, at least two field trips each year expose students to economic and cultural opportunities in their community.

Role modeling is another component and involves speakers, teachers or other individuals who have overcome barriers to success. Bilingual, culturally-sensitive staff visit the youth's home to increase parental involvement. Throughout the year, the contributions of the student tutors are recognized with t-shirts, caps, certificates of merit, field trips, media attention and an acknowledgment luncheon for their efforts. An annual awards ceremony brings together tutors, school personnel, parents and community leaders.

In 1987, the U.S. Department of Education's Office of Bilingual Education and Minority Language Affairs office selected *VYP* as a national research and demonstration project. In 1991, the program won approval from the U.S. Department of Education's Program Effectiveness Panel for inclusion in the National Diffusion Network. A year later, *VYP* received funding from the National Commission on Service Learning for program replication. In 1996, the program was operating in Los Angeles, Miami and San Antonio and seven other cities with plans to expand to Atlanta, Chicago and Washington, D.C.

Services Available

The IDRA newsletter, annual national training seminar, videos, fact sheet, information brochure with cost estimates, training, technical assistance, materials and evaluations are available. Materials and services are provided on a pro bono basis for those districts unable to find sources of funding to pay tutor stipends. Typically, districts use Chapter I, Chapter II, State Compensatory and Migrant Funds (federal and state funds) to pay for the stipends.

Implications for Practice

During adolescence, dropping out of school is associated with multiple social and health problems including substance abuse, delinquency, intentional and unintentional injury, and unintended pregnancy. *Healthy People 2000* objective 8.2 calls for increasing the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. The national educational goals also call for increasing the percentage of students who graduate from high school.

Audience		
	P	
	K[3]	
	4[6]	✓
	M	✓
	H	✓
	K[12]	
	S	

Locale		
	R	
	U	
	S	
	M	✓

Level		
	Cl	✓
	B	
	D	
	Co	

Components		
	C	
	St	
	Pe	✓
	Pa	✓
	M	
	P	
	Sk	✓
	Se	✓

Emphasis		
	K	
	A	✓
	N	
	B	✓

Linda Cantu
Program Director
Intercultural Development Research Association
5835 Callaghan, Suite 530
San Antonio, TX 78228-1190
PH: (210) 684-8180 / FAX: (210) 684-5389

Coca-Cola Valued Youth Program

	E	Design
✓	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
	Qn	
✓	B	
✓	F	Type
	S	
✓	O	
	P	

Evidence of Program Effectiveness

Several studies have evaluated this project. Data from a 1996 study was incomplete. Consequently, this summary discusses the findings from the first quasi-experimental evaluation done between 1988 (baseline) and 1990.

Participants and control students attended one of four campuses in two public school districts in a low-income area of San Antonio with large concentrations of Hispanic students. One hundred one tutors and 93 comparison group students met two criteria: limited English proficiency as defined by Texas state guidelines and reading below grade level on a standardized achievement test. The tutors and the comparison group came from the same pool of at-risk students. After selection of the tutoring group, mainly on the basis of class scheduling and availability, the comparison group was randomly selected from the remaining pool of at-risk students. At pretest, the only statistically significant difference between groups was in eligibility for free or reduced lunches. Tutors had significantly lower socioeconomic status than youth in the comparison group.

Pre/posttest measures included student grades, disciplinary action referrals, absenteeism, self-concept (using Piers-Harris Children's Self-Concept Scale) and quality of school life (using a self-administered 27-item questionnaire). In addition, teacher/coordinators and counselors from each of the four participating campuses participated in focus group interviews at the end of the first and second years of implementation. Elementary school representatives participated in the 1990 interviews. This formative information guided refinements to the program the second year.

The results of the study suggest that the *VYP* had a positive impact on the dropout rate, reading grades, self-concept and attitude toward school. One tutor out of 101 (1 percent) dropped out of school towards the end of the second year of the program, compared with 11 students out of 93 (12 percent) in the control group. In addition, tutors gained nearly three points more than the comparison group on the reading grade between 1987-88, and again in 1989. Measures of self-concept and attitudes toward school showed higher scores for *VYP* tutors than the comparison group during the first year of the program, however the program did not appear to effect scores for either measure the following year.

Critique

The evaluation found the *Valued Youth Program* very promising. Random assignment of tutors and/or schools to the program could strengthen future studies. To assess the service learning component of the program, comparison schools could receive an equivalent amount of time, attention and resources that directly focused on academic skills for at-risk students. Assessment of the program's effects on tutors would also prove interesting. The *VYP* appears to require extensive funding support which might exceed the range of many public schools.

Evaluation Contact

Jose A. Cardenas, PhD
Intercultural Development Research Association
5835 Callaghan, Suite 350
San Antonio, TX 78228-1190.

Community of Caring

Program Description

The Community of Caring (*COC*) is a values education program for students in kindergarten through high school. Created in 1982 by Eunice Kennedy Shriver, *COC* is a project of the Joseph P. Kennedy, Jr. Foundation. Originally *COC* targeted pregnant adolescents in middle and high school with a program to prevent repeat pregnancies. The current focus is on prevention and emphasizes the importance of abstaining from early sexual activity and deferring childbearing until marriage. It also encourages abstinence from alcohol and other drug use and stresses the importance of personal health. As a comprehensive approach, *COC* also addresses improved school performance, community service and planning for the future.

The program's goal is to strengthen students' ethical decision-making skills by promoting the values of caring, family, respect, trust and responsibility. *COC* is not a curriculum, but rather an infusing of values into whatever curricula schools currently use in all academic areas and throughout the school day. In 1990, Glencoe/McGraw-Hill published *Growing Up Caring*, a middle school text based on the values approach of the program. Throughout the school day, teachers use classroom discussions to bring the core values to the subject at hand. The community service projects promoted as part of *COC*, whether in or out of school, reinforce the core values, as do activities that involve families. Teen forums, planned, implemented and led by students in collaboration with teachers and community leaders, provide opportunities for young people to speak their minds and offer suggestions for community improvement, as well as to work collaboratively with caring adults on joint projects. The National Association of Secondary School Principals has endorsed *COC* and as of 1996, over 2000 schools in 18 states had received training as *COC* schools.

Services Available

Two days of on-site training with a single trainer costs $2,650. Materials for middle and high school cost $30 per participant and $15 per pupil for elementary. The *COC* office offers on-going technical support by phone.

Additional staff development is available on-site or at the summer institute held at the Foundation in Washington, D.C. Program staff, teachers and principals who have implemented the program lead the summer institute.

Implications for Practice

Unintended pregnancies among adolescents are a problem in the United States. Since the 1970s, the rate of sexual activity among adolescents has increased and the age of initiation of sexual activity has declined. Although teen pregnancy rates declined between 1990 and 1995, rates in the United States are among the highest in the developed world. *Healthy People 2000* objective 5.8 calls for an "increase to at least 85 percent the proportion of people aged 10-18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school or religious programs." *Healthy People 2000* recognizes the need for efforts "to strengthen the family's ability to educate and transmit strong values surrounding sexuality to children in the midst of a media culture that portrays and often condones casual sexual involvement. Postponement of sexual activity until an individual is in a mutually monogamous relationship is the most certain approach to prevention of a host of sexually transmitted disease and may also help reduce rates of unintended pregnancy."

Although less well researched than pregnancy prevention programs based on social and cognitive learning theories, programs including character education and service learning have recently shown promise as a new strategy to reduce high-risk behaviors among youth. *COC* offers an alternative strategy to reduce destructive behaviors among youth.

Audience		
	P	
	K^3	
	4^6	
	M	
	H	
	K^{12}	✓
	S	

Locale		
	R	
	U	
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	M	✓

Level		
	Cl	✓
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	D	
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Components		
	C	✓
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	Pe	
	Pa	✓
	M	
	P	
	Sk	
	Se	✓

Emphasis		
	K	
	A	
	N	✓
	B	

Wendy Hirsch
Program Coordinator
Community of Caring
1325 G St. NW, Suite 500
Washington, DC 20005-3104
PH: (202) 393-1251 / FAX: (202) 824-0200

Community of Caring

	E	Design
✓	Q	

✓	I	Analysis
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	QI	Data
✓	Qn	
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	F	Type
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✓	O	
	P	

Evidence of Program Effectiveness

In 1988, the Center for Health Policy Studies in Columbia, Md. evaluated the *COC* program in six high schools in three schools systems. They tracked a cohort of 1,777 ninth-graders for two years. For each program school, evaluators used racial composition and socioeconomic status to identify a comparison school within the same district. The sample represented a cross-section of racial groups. Separate analyses examined the program's effects on a subset identified as "at risk" for early sexual activity and poor school performance. At risk meant having a grade point average less than 2.5 and indicating at baseline that it was "okay" to begin having sex before or during high school.

Students completed a seven-part survey in the fall of 1988, in the spring of 1989 and spring 1990. The seven parts included demographic information; multiple choice knowledge; personal feelings of self-esteem based on the Rosenberg scale; attitudes toward school, family, risk taking and community service; a modified version of the Family Relations Scale on the quality of family relationships; self-reported behaviors (not including sexual behaviors); and personal values using an adapted version of the Life Values Scale developed by Harriet McAdoo. A panel, then pilot testing, established the survey's face validity and clarity. No reliability data is in the report. Evaluators also obtained data on academic performance, disciplinary actions, attendance records, and pregnancy incidence (one school only). Pregnancy incidence was the number of pregnant students attending school. Attrition varied by site: 50 percent of the Richmond, Va. students completed all data collection; in Kansas City, Mo. 71 percent completed and in Sacramento, Calif. only 33 percent completed for an average of 49 percent (N=877). Data analysis compared standardized effect scores to control for large sample sizes.

Findings varied by district and "at-risk" status. *COC* in Richmond was most successful in influencing students to adopt the core sexual values of the *COC* program – sexual abstinence until marriage, marriage is the best circumstance for having a baby, postponing sex is good as is preparing for the future. The Kansas City *COC* program was most successful in promoting some secondary values of *COC* – helping others and valuing school, personal health and one's family.

Students in *COC* schools in all sites improved their grade point average relative to the comparison schools. At the end of the two-year period, more Richmond students, including at-risk students, compared to those in the control school reported abstaining from alcohol and smoking, had significantly fewer not-excused absences and fewer disciplinary actions. Also in Richmond, the one school that documented pregnancies, the number of pregnant students dropped from 14 in 1988 to two in 1990. *COC* did not influence self-esteem or locus of control.

Critique

The quasi-experimental design suffered from serious attrition problems. The evaluators made no attempt to compare pretest measures of those lost to the study with those retained. It is quite possible that students at greatest risk left school before the posttest measure, thus accounting for pre/post differences. In California, some students had attended a *COC* school in middle school, thus possibly contaminating the control group in the second year. Other limitations include lack of information on the duration, intensity and method of program delivery as well as on programming in the comparison schools. No reliability data was provided on survey instrument. Use of standard effect scores limits the ability to compare results with other prevention programs.

Although the study claims positively influencing sexual behaviors, the survey asked no questions about sexual behaviors. The only sexual measures were knowledge and attitude items. In one of six schools, evaluators determined the number of pregnant students, but they presented no evidence that they looked for students who might have left school due to pregnancy. Despite these weaknesses, *COC* is one of the few values-oriented programs that have been evaluated. It shows promise for reducing substance abuse and improving academic performance.

Evaluation Contact

Rebecca Anderson
Executive Director
Community of Caring
1325 G St. NW, Suite 500
Washington, DC 20005-3104
PH: (202) 393-1251 / FAX: (202) 824-0200

Decker Family Development Center

Program Description

Founded in 1990, the *Decker Family Development Center (DFDC)* provides holistic "one-stop" medical, educational and social support services to low-income residents in an Ohio suburban community of 28,000. On an annual basis, *DFDC* serves approximately 325 parents and 435 preschool children in a former elementary school. Most families stay with the program approximately two years. Most participants are white, single-parent families who live in public housing with annual incomes below $10,000. More than 80 percent of the parents have literacy functioning below the ninth grade. The program's goals are to help parents assume their role as a child's most significant teacher; provide support and skills that enable parents to help their children reach their developmental potential; ensure that children will remain in school and that preschool children are developmentally ready to enter kindergarten; provide multiple services to children with special needs and help families become self-sufficient.

The services that the *DFDC* provides include special needs and regular child care, Head Start, parent education programs, training for displaced homemakers, GED classes, literacy programs and pre-employment training. Health services include family and pediatric medicine, occupational and physical therapy, food services and nutrition education and mental health services including crisis counseling, therapy, and stress management. Other services include employment services, home visitation and outreach, public assistance eligibility evaluations, legal services and computer skills training. To provide these services, the Center collaborates with 22 other agencies including the local school system, a nearby university, a regional children's hospital, county health and social service agencies.

The *DFDC* has developed a model for school-linked service centers and identified five elements required of participating organizations to achieve successful community collaboration: Participating organizations must devoid themselves of organizational territoriality issues, increase meaningful communication, share authority and power, negotiate goals and objectives and work toward their successful implementation, and have and publicly display a sense of shared ownership.

The Decker model distinguishes between cooperatives in which organizations participate in order to fulfill their own mission and agenda and collaboratives where the lines between who provides what service become blurred and decision making becomes a shared process among the principal service providers. In the Decker model, a hallmark of true collaboration is that the clients sit on the decision-making body.

In 1994, the *DFDC* received a NOVA award from the American Hospital Association and Hospitals and Health Networks in recognition of its work in providing a model service delivery system.

Services Available

The *DFDC* staff will provide technical assistance to others interested in establishing similar service delivery projects. It has several program monographs available at a cost ranging from $5 to $20.

Implications for Practice

Healthy People 2000 offers a vision of America's future characterized by significant reductions in preventable death and disability, enhanced quality of life and greatly reduced disparities in the health status of populations within society. Progress toward achieving this vision will depend, in large measure, on the degree to which certain subpopulations show substantial improvements. Low-income families are at especially high risk for adverse health outcomes. For nearly every measure of health, the poor suffer more than the population as a whole. The number of people in poverty, a third of whom are children, continues to grow. The *Decker Family Development Center* offers a model by which schools and families can receive services that help ensure that children are healthy and will enter school able and ready to learn.

Audience	
P	✓
K[3]	
4[6]	
M	
H	
K[12]	
S	✓

Locale	
R	
U	
S	✓
M	

Level	
Cl	
B	
D	
Co	✓

Components	
C	
St	
Pe	
Pa	✓
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	
N	
B	✓

Mary Frances Ahern
Director
Decker Family Development Center
633 Brady Ave.
Barberton, OH 44203
PH: (330) 848-4264 / FAX: (330) 848-0884

Decker Family Development Center

Design	
	E
✓	Q

Analysis	
✓	I
	G
	B
	D
	C
	M

Data	
	QI
✓	Qn
	B

Type	
	F
	S
	O
✓	P

Evidence of Program Effectiveness

A process evaluation study of the *DFDC* from 1993-95 started with 235 families referred for services. Of these, 94 (40 percent) were referred to other agencies prior to the start of the study. The remaining 141 completed a demographic profile that included parents' literacy functioning and employability status. Seventy-six percent of those in the study were single women with children. Four percent had a GED and 27 percent had graduated from high school, yet 82 percent functioned at less than a high school level of literacy. Seventy-five percent had an annual income of less than $5,000. According to the Learning Accomplishment Profile (LAP) and Early Learning Accomplishment Profile (E-LAP), 64 children (80 percent) were developmentally delayed. At intake, adults took a test measuring four domains of functionality: personal/family, educational, self-sufficiency and global in which a Level 1 score indicated minimal at-risk functioning and Level 5 represented profound at-risk functioning. At the end of the school year, 124 (88 percent) adults and 157 children completed a post program assessment.

Within six months, 40 individuals (28 percent) left the program because of success. Of these, 15 (38 percent) achieved their GED, 18 (45 percent) got a job, and seven (18 percent) went to college or a trade school. Another 17 (12 percent) left the program due to moving, medical reasons or quitting and 84 (60 percent) continued to attend regularly. Of those who remained in the program for a year, dependent t-tests revealed that 37 percent significantly improved in at least one domain of functionality. By the end of six months, two of the 10 individuals taking the posttest who were initially assessed as "profoundly at risk" (Level 5) had progressed to level 3 (medium risk), six had moved to level 2 (some risk) and two remained at level 5. However, many families assessed as being "most at risk" did not continue in the program long enough to take the posttest and were not included in the analysis.

Critique

The *Decker Family Development Center* offers a model for comprehensive school-linked health and human services that addressed the needs of preschool children and their low income parents. The program evaluation indicates that *DFDC* shows promise. However, without a rigorous, well designed evaluation that uses a comparison group it is not possible to determine the model's effectiveness in enhancing children's health and well-being or future achievement in school.

Evaluation Contact

Brian Pendleton, PhD
Department of Sociology
University of Akron
Akron, OH 44325-0604

Developmental Approaches in Science and Health

Program Description

Developmental Approaches in Science and Health (DASH) is a comprehensive science, health and technology program for grades K-6 developed by the Curriculum Research and Development Group (CRDG) of the College of Education, University of Hawaii in 1986.

DASH encompasses all six dimensions of scientific literacy advocated by *Project 2061, Science for All Americans* through hands-on inquiry intended to nurture the development of students' cognitive, kinesthetic and interpersonal skills. Individual and group activities focus on making sense of new information, making connections with what is already known and using new knowledge to expand understanding of the world. Health-related activities are developmentally appropriate to coincide with topics of immediate interest to the students. Students in grades K-3 become nutritionists, safety engineers and health service workers while studying disease transmission, sanitation, nutrition, safety and personal physiology. Study in the upper elementary grades expands to human reproduction and the dangers of drugs, tobacco, alcohol and sexually-transmitted diseases. An emotional health focus is interwoven throughout all grades emphasizing social interaction and personal responsibility.

Materials and activities are specifically designed for use by teachers in self-contained classrooms, but they can also be used successfully by science specialists. *DASH* does not require kits of science materials, but uses equipment students make from throwaway items commonly available. In addition, *DASH* stresses connecting its activities to experiences at home. *DASH* 's K-3 portion was validated by the U.S. Department of Education's National Diffusion Network in 1992-93 and is currently in use in 28 states, as well as Australia and New Zealand.

Services Available

Classroom materials are available only to teachers who complete an intensive 10-day *DASH* teacher institute. Institutes are offered at several stateside universities and are tailored to the grade level for which the teacher expects to teach. The teacher's guide contains approximately 100 activities per grade level and masters for activity sheets.

Monthly support services and technical assistance are available from the CRDG. A series of newsletters called *DASH on Home* are available for parents, while teachers receive a *Science Education* newsletter at no cost. Cost per classroom, including training, instructional materials and support services, average $525 for 22 students for the first year, $200 the second year and $100 the third year.

Implications for Practice

The use of critical thinking, problem-solving and cooperative interpersonal skills have been cited as important factors in reducing high-risk behaviors. *DASH* provides very young children with fundamental tools to build self-efficacy and promote self-responsibility. Engaged learners tend to require less discipline and classroom management. In these days of shrinking resources and time, *DASH* provides teachers with an integrated approach to science, health and technology that articulates well with language arts, mathematics, music, art, social studies and physical education. The program is not textbook dependent and has been shown to promote self-directed learners actively engaged in discovery and application of new information.

Audience	
P	
K^3	✓
4^6	✓
M	
H	
K^{12}	
S	

Locale	
R	
U	
S	
M	✓

Level	
Cl	✓
B	
D	
Co	

Components	
C	✓
St	✓
Pe	
Pa	✓
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	
N	
B	✓

Donald B. Young
Associate Director
Curriculum Research and Development Group
University of Hawaii
1776 University Ave.
Honolulu, HI 96822
PH: (808) 956-6918 / FAX: (808) 956-4114
e-mail: young@uhunix.uhcc.Hawaii.edu

Developmental Approaches in Science and Health

	E	Design
✓	Q	
	I	Analysis
✓	G	
	B	
	D	
	C	
	M	
✓	QI	Data
	Qn	
	B	
	F	Type
✓	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

DASH was field-tested in rural, suburban and urban public and private schools in Hawaii involving 1,200 teachers and 30,000 students. In addition, 650 teachers and 20,000 students in six states participated in field testing. Because of the difficulty in obtaining valid and reliable statistical data from children in grades K-3, CRDG used a multiple-case study design in seven districts in Hawaii, Pennsylvania, North Carolina and Washington to evaluate the project. The analysis followed cross-experiment rather than within experiment logic and design. Based on Yin (1989), this method allowed the evaluators to claim replication if two or more cases supported the same assertion.

A study team of 11 trained, senior researchers conducted the site visits in teams of two or three investigators over a five-day period. Teams interviewed and recorded teachers, administrators, parents and students and took voluminous field notes. Data was collected on student-created products and artifacts, engaged learning time, test data where available and teacher lesson plans. Each site team wrote single case study reports and prepared site portfolios. These study reports were coded to field notes and data interpretation was verified by team members, teachers and administrators. An independent evaluator, Dr. James Gallagher of Michigan State University, examined the case studies for patterns which matched the predicted student and teacher outcomes derived from the *DASH* constructionist framework and did the cross-case analysis.

Due to the diversity of study sites, multiple data sources at each site and multiple perspectives of team members at each site, any common findings were interpreted to provide strong evidence of the impact of the curriculum.

Based on the observations, artifacts, documents and structured interviews, three claims of effectiveness were made for the K-3 *DASH* curriculum to the Program Effectiveness Panel of the National Diffusion Network.

Only statements corroborated by more than one type of data were offered in evidence. First, students who participated in *DASH* were able to demonstrate understanding of fundamental concepts and use of basic inquiry skills and data gathering techniques in science, health and technology . Students were able to demonstrate integration and application of these concepts. Second, *DASH* students were self-directed learners who took responsibility for their own learning. This was demonstrated in engaged learning time (85-95 percent), planning and completion of tasks and use of multiple resources. Third, experienced *DASH* teachers in grades K-3 changed their attitudes and approaches in ways resulting in increased instructional time and focus on students' learning. Rather than giving answers, teachers created an environment that enabled students to actively engage in the inquiry process.

Critique

The evaluation appears to confirm that *DASH* was successful in addressing the recent national initiatives on science education reform. These reforms seek to replace textbooks with integrated, hands-on inquiry programs intended to promote scientific literacy, responsibility and critical thinking. Some may challenge the reliance on qualitative evidence to justify the claims of effectiveness.

Evaluation Contact

Donald B. Young
Associate Director
Curriculum Research and Development Group
University of Hawaii
1776 University Ave.
Honolulu, HI 96822
PH: (808) 956-6918 / FAX: (808) 956-4114
e-mail: young@uhunix.uhcc.Hawaii.edu

EAT SMART

Program Description

The *Child and Adolescent Trial for Cardiovascular Health (CATCH)* program, was a multi-site research project to reduce risks of cardiovascular disease among elementary school students and adolescents. Funded by the National Heart Lung and Blood Institute (NHLBI), the program had several components: a physical education program, *CATCH PE*; heart health education curricula for the third; fourth and fifth grades; family involvement activities; and *EAT SMART*, a food service program.

EAT SMART meets all the requirements for reimbursable meals as specified by the U.S.D.A. National School Lunch and School Breakfast programs. In addition, the average recommended meal provides a total fat level of no more than 30 percent of total energy, a saturated fatty acid level of no more than 10 percent of total energy, a reduction of 25 percent in sodium levels to 600 to 1000 mg. for school lunch and no more than 500 mg. for school breakfast. Program objectives include ensuring that cafeteria meals provide the recommended levels of essential nutrients and meet students' tastes.

EAT SMART addresses six areas: menu planning, field-tested recipes that serve 100, purchasing both commodity and vendor-prepared foods that meet the dietary guidelines, preparation methods, food production, and food merchandising and promotion. Promotional materials include table tents, laminated posters, menu messages and bulletin boards.

Implementation of *EAT SMART* usually takes two to three years. Food service directors, managers, supervisors and cooks/technicians need at least eight hours of staff development that includes both information and skills-based activities. Booster sessions and opportunities to discuss follow-up experiences enhance program success.

Services Available

The training manual (order #55-733) costs $35, with a 10 percent discount for orders of three or more.

Implication for Practice

Cardiovascular disease is the leading cause of death in the United States. Epidemiological data has linked cardiovascular disease to lifestyle habits including tobacco use, diet and sedentary lifestyle among others. These behaviors begin early in life and many children already possess one or more major risk factor by the time they begin school. They learn others during childhood and adolescence.

The National School Lunch Program includes 99 percent of public schools in the nation and feeds more than 25 million children daily. Schools, thus, offer an ideal setting for encouraging healthy dietary practices by reinforcing nutrition education in the classroom with food choices in the cafeteria. *Healthy People 2000* objective 2.17 calls for increasing to at least 90 percent the proportion of school lunch and breakfast meals that are consistent with current dietary recommendations for Americans. Schools can introduce *EAT SMART* with minimal but concentrated efforts that include staff training and modest follow-up support. It provides a model for effective nutrition services, and contributes to risk reduction for students from diverse ethnic/cultural and socioeconomic backgrounds.

Audience		
	P	
	K[3]	✓
	4[6]	✓
	M	
	H	
	K[12]	
	S	

Locale		
	R	
	U	
	S	
	M	✓

Level		
	Cl	✓
	B	✓
	D	
	Co	

Components		
	C	✓
	St	✓
	Pe	
	Pa	
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	
	N	
	B	✓

to order materials:
Information Center
National Heart, Lung
and Blood Institute
P.O. Box 30105
Bethesda, MD 20824-0105
PH: (301) 251-1222
FAX: (301) 251-1223.

for program information:
Eileen P. Newman, MS, RD
Public Health Advisor
National Heart, Lung
and Blood Institute
P.O. Box 30105
Bethesda, MD 20892
PH: (301) 594-1596

EAT SMART

✓	E	Design
	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
✓	M	
	QI	Data
	Qn	
✓	B	
	F	Type
✓	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

The evaluation of *EAT SMART* was part of the overall *CATCH* evaluation that involved 96 public schools from 12 school districts in Texas, Louisiana, California and Minnesota. The schools were randomly assigned to receive the program (56 schools; 14 per field site) or serve as comparison (40 schools; 10 per field site). Further randomization divided the program into two subgroups: one group received a school-based program consisting of *EAT SMART*, *CATCH PE* a physical education program and heart health education curriculum for grades 3-5; the other group received the same program plus a family-based program. The study followed 5,106 children, 69.1 percent White, 14.1 percent Hispanic, 13 percent African-American and 3.8 percent other who were in the third grade at baseline for three years (1991-94).

Assessments of students' dietary practices included the Health Behavior Questionnaire, a self-administered instrument and a 24-hour dietary recall that measured total daily food and nutrient intake of a random sub-sample of 30 students per school at both baseline and follow-up. Reliability and validity of these instruments was acceptable. Other measures included blood pressure readings and lipid levels of non fasting venipuncture samples.

Researchers conducted nutrient analysis of recipes and vendor-supplied foods that were high in fat or sodium, served frequently or had no nutrient information available. Analysis of student intakes, menu items and food recipes for protein, total fat, saturated fat, carbohydrate and sodium used the Nutrition Data System. Interviews of cafeteria managers and individual technicians provided detailed information about recipe ingredients, food preparation techniques and methods of service. Recipes included weights and measures of each ingredient, preparation methods, form of ingredient (fresh, frozen, canned, etc.), recipe modifications, portion weights and measures and yields. Information on items came from labels and considered preparation methods and portion sizes. Another measure involved direct observation of trayline presentation and meal service.

Findings revealed that the types of modifications school food service staff made and the degree to which they made modifications varied across sites. Differences were most often due to the structure of food service delivery, availability of lower fat and lower sodium foods at an affordable price, local norms in menus and recipes, the availability of trained personnel and equipment, and time constraints. Sites with the greatest degree of implementation produced the greatest changes.

Across sites, student daily energy intake from fat decreased significantly from 32.7 percent to 30.3 percent in program schools compared to comparison schools ($p < 0.001$). Much of this difference came from a decreased intake of saturated fatty acids. In addition, dietary cholesterol decreased in the program schools (223 mg. to 206 mg. vs. 218 mg. to 225 mg.). Total blood cholesterol declined in both conditions but the difference was not statistically significant. Sodium consumption marginally increased in program schools. A comparison of nutrients from 45 selected menu items before and after the program showed a 10.9 percent decrease in total fat (from 40.9 percent of the diet to 36.4 percent), a decrease by 13.1 percent of saturated fatty acids, and a 13 percent decrease in the sodium content of the menus.

Critique

CATCH, to date, is the largest and most rigorous school-based health promotion field trial that has been implemented in the United States. It met several of its primary objectives, most notably changes in children's eating patterns to achieve the national goals for consumption of fat and cholesterol. *EAT SMART* successfully educated food service personnel about preparing healthy meals and modified students' attitudes and food choices at lunch. The study detected no significant changes in students' serum cholesterol level. Other studies have found modification of children's cholesterol levels difficult, and perhaps unwarranted in the absence of high risk.

Evaluation of *EAT SMART* occurred as part of a study of a comprehensive intervention that also included classroom instruction and modifications in physical education. The study did not examine *EAT SMART* as a stand-alone program.

Evaluation Contact

Theresa A. Nicklas
Tulane Medical Center
School of Public Health
New Orleans, LA 70112

Florida Traffic and Bicycle Safety

Program Description

The Florida Department of Transportation's Safety Office launched a bicycle and pedestrian safety education program for fourth-grade students in 1984, modeled after a program in Montana. In 1991 the University of Florida's Department of Urban and Regional Planning assumed responsibility for the program, revised it and expanded it for grades K-8. The curriculum for grades K-2 focuses on pedestrian safety. Students learn specific skills such as stopping at the edge of the sidewalk and searching left-to-right-to-left. For third- to fifth-grade students, the curriculum emphasizes bicycle safety. Lessons include outside, on-bike practice with bicycles purchased and kept by the participating school. Specific skills include proper signaling and avoiding road hazards. The curriculum also teaches decision-making skills, balance, eye-hand-foot coordination, increased awareness of the neighborhood and surroundings, and exercise. The middle school component became available in 1995, but was not part of the evaluation study. Classroom instruction includes interactive video components and activity sheets. Physical educators most often teach the curriculum.

When originally revised, Florida was preparing to implement mandatory bike helmet laws. Given a large demand for the curriculum and few resources to provide staff development, a 10-hour "train-the-trainer" model was developed to prepare educators, youth leaders and resource officers to teach children safe practices in and near automobile traffic. University of Florida staff train trainers, who in turn, instruct teachers and other interested individuals in their area. Since 1992-93, approximately 667 teachers, police officers, local bicycle pedestrian coordinators, community officials and other interested individuals in 24 Florida counties have received training. These counties represent 75 percent of the state's population.

Services Available

Through the regional trainers, the University of Florida provides teacher training, workshops and curriculum materials. The 10-hour training generally takes a day-and-a-half and when possible incorporates a teacher in-service day. To offer training, the University of Florida requires a minimum of 15 and maximum of 50 participants.

Implications for Practice

Injuries are the leading cause of death among school-aged children. Among children ages 5-9, traffic injuries are the leading cause of death and disability. Helping children develop safe traffic behaviors and avoid hazards, thus, can help save lives and reduce injury and disability. *Healthy People 2000* objective 9.13 specifically addresses the need to increase the use of bicycle helmets. As of 1994, nine states required helmets for bicycle riders. Such laws are particularly important in states, like Florida, that offer year-round opportunities for riding. Objective 9.18 calls for "academic instruction on injury prevention and control, preferably as part of comprehensive school health education, in at least 50 percent of public school systems." The *Florida Traffic and Bicycle Safety Education Program* offers a structured, developmentally-appropriate program at the earliest grades to raise awareness and provide basic skills.

Audience	
P	
K^3	✓
4^6	✓
M	
H	
K^{12}	
S	

Locale	
R	
U	
S	
M	✓

Level	
Cl	✓
B	
D	
Co	

Components	
C	
St	✓
Pe	
Pa	
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	
N	
B	✓

Dr. Linda B. Crider
Margaret Raynal
Department of Urban and Regional Planning
431 ARCH, P.O. Box 155706
University of Florida
Gainesville, FL 32611-5706
PH: (904) 392-8192, Suncom 622-8192
FAX: (904) 846-0404

Florida Traffic and Bicycle Safety

	E	Design
✓	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
	Qn	
✓	B	
	F	Type
	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

In 1996, the Florida Department of Transportation contracted with the University of Florida to evaluate the training model and students' learning. Data included surveys of students in selected schools to measure knowledge, attitudes and beliefs; focused interviews of teachers and administrators involved in the program, participant-observations by the evaluation team; and surveys of the teacher-trainers.

Student questionnaires were pilot tested for developmental appropriateness and content validity. Teachers or graduate students administered questionnaires to 1,171 children in five elementary schools in three counties. Usable surveys were obtained from 1,151 students (98 percent). In grades K-2, the data revealed statistically significant positive associations ($p<.10$) between the curriculum and children's understanding of traffic rules. The third- to fifth-grade findings demonstrated statistically significant evidence that the curriculum improved knowledge of bicycles and rules for riding in traffic. However, there was no evidence of increased helmet use or improved bicycle skills. An interesting finding was that boys did not learn the concepts as readily as girls or failed to report them as correctly and consistently as girls.

Surveys of teacher-trainers were mailed to 395 eligible individuals who had been trained in the program. One hundred sixty-nine teacher-trainers (42.7 percent) returned useable surveys. The surveys consisted of multiple-choice questions about program environment, implementation, administrative support, community support, quality of curriculum materials, effect on children's behavior and the teacher training workshop. Surveys also allowed for comments. In addition, the investigators were participant-observers during two training sessions and informally interviewed members of the training classes. This information helped place the survey responses in context. The majority of trainers rated the program very highly across the entire range of categories with the exception of some of the video components, which were considered inappropriate and unhelpful.

The evaluators also conducted case studies that examined implementation issues. They conducted focused interviews of 37 individuals in seven counties. Counties were selected because they had exemplary programs, had interesting models of implementation or had given up trying to implement. The case studies revealed several common characteristics of successful programs as well as barriers to success. The problems most often cited included lack of time to implement the program, lack of financial support for the purchase and maintenance of a sufficient number of bicycles and quality helmets, and the need for a coordinator who can oversee the program in each district. Characteristics of successful programs included widespread support by businesses in the community; active involvement of parents and other adult service groups; positive, regular media coverage; and strong administrative support.

The evaluation included pre/posttests of students, but no control or comparison group. Measures did not include direct observations of behaviors.

Critique

Although specific pedestrian safety and bicycling skills were not assessed, the program increased young students' knowledge of important safety rules. It did not, however, appear to increase students' use of bicycle helmets. The purchase of bicycles by schools assured that the program was institutionalized although funding for maintenance and repair was a potential barrier to continuation.

Evaluation Contact

Richard H. Schneider, PhD
Principal Investigator
Department of Urban and Regional Planning
432 ARCH, PO Box 155706
University of Florida
Gainesville, FL 32611-5706

Get Real About AIDS

Program Description

Get Real About AIDS is an HIV prevention curriculum for students in grades 4-12. Originally developed in 1988 by the Comprehensive Health Education Foundation (CHEF), the program was first called *Here's Looking At AIDS And You.* It was updated in 1992 under the current name and further revised in 1994, when the high school unit of the curriculum was designated by the Centers for Disease Control and Prevention (CDC) as a *Program that Works!* and the other units were redesigned to be consistent with the high school unit. Only the high school unit has undergone evaluation. Thus, this review discusses only the high school level. The current high school package includes two lessons which were not part of the evaluated program: a simulated community meeting and a lesson delaying the onset of sexual activity. The program requires 14 class periods to complete.

Get Real About AIDS provides students with current and accurate information about HIV, AIDS and other sexually transmitted diseases. It teaches social skills that enable youth to say no, develop self-control and increases students' perception of their vulnerability to HIV. The instructional strategies draw on a variety of approaches including Hunter's Instructional Theory into Practice (ITIP); Botvin's social skills training; the Johnson brothers' cooperative team learning; and Hawkins and Catalano's risk reduction and changing of peer norms. *Get Real About AIDS* also presents and reinforces a strong no drug use message.

All levels of the program stress the benefits of abstinence from sex. The high school unit, however, provides a comprehensive approach to HIV prevention. Lesson plans are flexible and teachers can adapt them to fit their comfort level. The program incorporates activities that extend to school, family, and community and accommodates a wide range of learning styles through a mixed-media approach that includes games, books, videos and work sheets.

Services Available

The high school curriculum costs $495. The price includes a teacher's guide and all the materials needed to teach the curriculum, including videos, posters, lesson plans, fact sheets, masters for worksheets and a newsletter for parents. CHEF recommends three days of teacher training. Many state education agencies also offer training. Training costs depend upon need. Demonstration kits are offered for preview at no charge. Technical assistance for implementation is available by phone and mail.

Implications for Practice

Every year in the United States, young people between the ages 13 and 21 account for an estimated 25 percent of new HIV cases. In other terms, approximately two youth get infected with HIV every hour of every day. *Healthy People 2000* Objective 18.3 calls for reducing the number of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. Objective 18.4 seeks to increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last intercourse. The *Healthy People 2000 Midcourse Review and 1995 Revisions* reported mixed success in meeting these objectives. The percentage of 15-year-olds who are sexually active remains high, although the numbers have declined slightly. At the same time, condom use at last sexual intercourse among high school students has increased. Effective education programs, such as *Get Real About AIDS*, are one weapon in the fight to protect young people from infection with HIV and other sexually transmitted diseases.

Audience		
	P	
	K[3]	
	4[6]	✓
	M	✓
	H	✓
	K[12]	
	S	

Locale		
	R	✓
	U	
	S	✓
	M	

Level		
	Cl	✓
	B	
	D	
	Co	

Components		
	C	✓
	St	✓
	Pe	
	Pa	✓
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	✓
	N	✓
	B	

for information, materials
AGC Educational Media
1560 Sherman Ave., Suite 100
Evanston, IL 60201
PH: (800) 323-9084
FAX: (847)328-6706

for training
1. CHEF (800)323-2422
2. National Training Partnership at EDC (617) 969-7100
3. Julie Taylor, ETR Associates (408) 438-4060

Get Real About AIDS

	E	Design
✓	Q	

	I	Analysis
	G	
✓	B	
	D	
	C	
	M	

	Ql	Data
	Qn	
✓	B	

	F	Type
✓	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

In the fall of 1991, six school districts in Colorado delivered the *Get Real About AIDS* program to students in grades nine through 12. Using a quasi-experimental design, seventeen schools received either the program (n=10) or served as a comparison group (n=7). Within each district, schools were matched on grade, gender, and racial and ethnic distribution. Program schools received the curriculum for 15 consecutive school days. In addition, many schools implemented activities that reinforced the themes of the lessons, such as displaying HIV posters throughout the school and distributing wallet-sized HIV information cards to students in nonparticipating classes. In the control schools, teachers offered their usual HIV education.

Students completed a self-report questionnaire at baseline, at the end of the first semester, and at the end of the school year (i.e. six months after the program). A total of 979 students completed both baseline and six-month, follow-up data. In addition, trained observers collected program implementation data a minimum of three times to determine the extent that students received the entire curriculum (completeness) and the extent that teachers adhered to specific activities within each lesson (fidelity).

The study found that students who received the program were more likely than students in the control group to report they had purchased a condom. Compared to the control group, sexually active students in the program group reported having fewer sexual partners within the past two months and using a condom more often during sexual intercourse. Students who received the program scored significantly higher on a knowledge test of HIV and expressed greater intention to engage in safer sexual practices than comparison students. Program students were more likely to believe that someone their age who engaged in risky behaviors could become infected with HIV. The program did not, however, significantly postpone the onset of sexual intercourse.

Classroom observations indicated that teachers included 75 percent of the lesson components and taught those components with 89 percent fidelity. The majority of teachers rated all lessons as more effective than their usual lessons and reported extremely positive student reactions.

Critique

Of the 2,015 students who completed the baseline instrument, the evaluator matched 66 percent at the six-month follow-up. Attrition in both the program and control schools was higher among those sexually active at baseline than among those who had never had sex. The only significant differences between control and program schools at follow-up was age – program students were somewhat older. Thus, results are generalizable to school-attending youth, but might not apply to higher risk students such as dropouts or those with frequent absences.

Evaluation Contact
Deborah S. Main, PhD
Department of Family Medicine
University of Colorado Health Sciences Center
1180 Clarmont St.
Campus Box B-155
Denver, CO 80220
PH: (303) 270-5191

Gimme 5

Program Description

Gimme 5 is a nutrition program for students in fourth and fifth grades based on social cognitive theory. It is designed to increase fruit and vegetable consumption. Tom Baranowski, PhD, and colleagues from the Medical College of Georgia, Emory University and the University of Minnesota developed *Gimme 5*. Research revealed that children do not eat fruits and vegetables for three reasons: they're generally not available or accessible in the home (an environmental factor); children do not like them (a personal factor); and children are often responsible for making their own meals and snacks, but do not have knowledge and skills to make recipes using fruits and vegetables (a skill factor).

To address these issues, *Gimme 5* encourages children to use "asking skills" to request their favorite fruits and vegetables at meals and at snacks, to ask to go grocery shopping with parents and to request visiting fast food restaurants that offer fruits and vegetables. To increase preference for fruits and vegetables, the program exposes children to new recipes using fruits and vegetables through food-tasting experiences. To improve children's food preparation skills, the program includes opportunities for children to prepare FaSST (Fast and low fat, Simple, Safe and Tasty) recipes. Strategies also help students develop skills in goal-setting, self-monitoring and problem solving.

Gimme 5 is a semiweekly, six-week course. The fourth-grade level focuses on vegetable consumption. The fifth-grade level focuses on fruit consumption added to vegetables to achieve five a day. Teaching strategies include raps, games, role-playing, mock newspaper columns, comic strips and rhymes. Four-page weekly newsletters for parents suggest simple recipes and family activities for use at home. The program recommends establishing a community advisory committee comprised of representatives from school administration, school food service, teachers, parents, grocers and area fast food managers.

Services Available

The fourth- and fifth-grade teachers' guides include 12 lessons at each grade level with behavioral objectives, and an outline for teaching, transparencies and student worksheets, ideas for enrichment activity ideas and six parent newsletters. In addition, each grade incorporates three, 15-minute, "MTV-style" videos. A food service handbook helps food service staff prepare the foods for taste-testing. One set of materials costs $250. *Gimme 5* recommends four hours of staff development training with a two-hour follow-up training midway through implementation.

Implications for Practice

Because dietary practices are often learned at a young age and carried into adulthood, establishing healthy dietary patterns at an early age is important. The *Year 2000 Health Objectives* and the U.S. Dept. of Agriculture/U.S. Dept. of Health and Human Services *Food Guide Pyramid* recommends increasing fruit and vegetable consumption to five or more daily servings. Currently, less than 25 percent of adults meet the minimal goal and most need to double their intake. *Gimme 5* addresses cognitive, affective and behavioral outcomes. It is one of four programs funded by the National Cancer Institute that focuses on increasing consumption of fruits and vegetables.

Audience		
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	K^3	
	4^6	✓
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	H	
	K^{12}	
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Locale		
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	S	✓
	M	

Level		
	Cl	✓
	B	✓
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Components		
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	St	✓
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	Pa	✓
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	✓
	N	✓
	B	✓

Janice Baranowski, MPH, RD, LD
Project Manager
Department of Behavioral Science
The University of Texas
M.D. Anderson Cancer Center
1515 Holcombe Blvd., Box 243
Houston, TX 77030-4095
PH: (713) 745-2383

Gimme 5

Design: [✓] E [ ] Q

Analysis: [ ] I [ ] G [✓] B [ ] D [ ] C [✓] M

Data: [ ] QI [ ] Qn [✓] B

Type: [ ] F [✓] S [✓] O [✓] P

Evidence of Program Effectiveness

The *Gimme 5* project was first evaluated in 1991 with 301 students in grades 4-5. Findings from that study found some evidence of dietary changes among elementary school children, however, most changes were school-site specific and did not occur at home. The program was subsequently revised to achieve dietary changes at home as well as at school. Parent newsletters and accompanying videos reinforced curriculum messages given at school. In addition, *Gimme 5* suggested point of purchase educational activities in grocery stores near participating elementary schools. The most recent evaluation occurred during 1994-96.

Sixteen elementary schools (four from a major southeastern metropolitan area and 12 from a suburban school system) were matched within the district by size, percent of students participating in free or reduced lunch and percent of annual student turnover. Within the matched pair, schools were randomly assigned to participate in the program or to serve as comparison schools. No substantial differences existed between groups at baseline. Teachers attended a six-hour workshop to become familiar with the program prior to implementation.

Baseline data was collected when the students were in the third grade. Cohort assessment occurred in March for the fourth and fifth grades. Over 1,700 children participated each year for three years; 80 percent of the students were White with the remainder primarily African American. There were no statistically significant differences by gender or ethnicity between those who dropped out and the cohort. The school served as the unit of analysis. A small random sample of parents also provided data via telephone interviews at each point in time.

The outcome evaluation used various assessment measures with adequate to good reliability. Students completed a seven-day food record according to a standardized protocol. Trained dietitians with intercoder reliability of .8 or above for three categories examined coded diaries. Other measures included knowledge, outcome expectations, self-efficacy, social norms and asking behaviors. Approximately 90 percent of the teachers participated in process evaluation conducted by classroom observers.

Trained dietitians analyzed school lunch menus, then verified or corrected the analysis with visits to the cafeteria. Telephone interviews with parents determined fruit and vegetable availability and accessibility. Finally, observation, survey and personal interview assessed point-of-purchase education.

Findings revealed increased vegetable consumption at year two in the treatment group compared to decreased consumption in the control group. Parent interviews suggested a positive increase in the availability of fruit and vegetables at home as a result of program. At year three no differences existed. Detectable changes occurred in school lunches but not at home. Nonetheless, *Gimme 5* appeared to mitigate an age-related decline in fruit and vegetable consumption observed in the control group and confirmed in national surveys. The lowest-consuming groups at baseline improved the most. The evaluators speculated that some developmental characteristics associated with this age group might make educational efforts difficult and that the increasing availability of competing food choices such as high fat/high sugar snacks reduced fruit and vegetable selection.

Critique

As noted by the researchers, a number of problems limit the conclusions from this evaluation. Process evaluation revealed that only 47 percent of teachers used all the activities and only 22 percent of the activities crucial to behavior change. Eighty-two percent of the parents reported receiving the video but only 65 percent viewed it. Sixteen grocery stores each conducted one point-of-purchase activity – all during the same month. Attendance at store events was low. Teachers were more comfortable presenting nutrition information than using techniques designed to promote behavior change.

Evaluation Contact

Tom Baranowski, PhD
Department of Behavioral Science
University of Texas
M.D. Anderson Cancer Center
1515 Holcombe Blvd.
Houston, TX 77030-4095
PH: (713) 745-2682
E-mail: tbaranow@notes.mdacc.tmc.edu

Going for the GOAL

Program Description

Going for the GOAL is a "life skills" program for middle school students designed to teach young adolescents a sense of personal control and confidence about their future. Developed in 1987 by Steven J. Danish, PhD, of The Life Skills Center at Virginia Commonwealth University, the program assists youth in identifying positive life goals and developing skills to attain these goals. Students learn how health behaviors can either compromise or impede goal attainment or facilitate goal achievement. Based on social learning principles, the program teaches students to identify their dreams, control their emotions, ask for help, overcome obstacles and rebound from setbacks as well as seek and create social supports. An assumption of the program is that success in life goes beyond knowing what to avoid; it also requires knowing how to succeed. For this reason the program emphasizes "what to say yes to" as opposed to "just say no."

The program consists of 10 one-hour skill based workshops taught by two trained high school students as part of the middle school health curriculum or after school programs. Activities include role plays, problem-solving skits, stories and games. Selected high school students must have at least a "C" average, leadership qualities and extracurricular involvement. These successful high school role models have grown up in the same neighborhoods, attended the same schools, and confronted similar roadblocks as their younger counterparts. Local colleges and universities often provide the training and supervision of the high school leaders.

Originally funded by a grant from the Center for Substance Abuse Prevention, *GOAL* has since used grants from public and private sponsors to spread to over 25 cities nationally. Since its inception, almost 15,000 students have received the program. In 1996, *GOAL* received the Lela Rowland Prevention Award by the National Mental Health Association. A new version of the program called *GOALS for Health*, funded by the National Cancer Institute, addresses the issues of healthy eating and tobacco use prevention among youth.

Services Available

The program includes leader manuals and student activity guides. The developers recommend identifying a school and community coordinating group to help implement and oversee the program. An operations manual can help facilitate that process. In addition, The Life Skills Center offers a one-day training program for school and community. The cost of the program varies, depending on the number of middle school students participating. For 100 students the price is approximately $40 per student. A Spanish version of the program is also available.

Implications for Practice

Many of the leading causes of death among adults are due to health risk behaviors that are preventable, such as smoking, lack of physical activity and poor dietary habits. Many of these negative habits begin in adolescence. The *GOAL* program uses peer role models to reach youth with general competency skills at a key stage in their development. This approach to prevention has shown considerable promise in helping students establish positive health habits and achieve success. In addition, the role models gain increased confidence and control over their lives as well as learn the specific content they teach.

Audience		
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	K[3]	
	4[6]	
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	K[12]	
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Locale		
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	M	✓

Level		
	Cl	✓
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Components		
	C	✓
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	Pe	✓
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	Sk	✓
	Se	

Emphasis		
	K	
	A	✓
	N	
	B	✓

Steven J. Danish, PhD
Director
The Life Skills Center
Virginia Commonwealth University
800 W. Franklin Street, Box 842018
Richmond, VA 23284-2018
PH: (804) 828-4384 / FAX: (804) 828-0239

Going for the GOAL

Design	
	E
✓	Q

Analysis	
✓	I
	G
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	D
	C
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Data	
✓	QI
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Type	
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✓	O
✓	P

Evidence of Program Effectiveness

A three-year qualitative evaluation of *GOAL* began in 1992 and involved 2,039 racially-mixed, sixth-grade students in Richmond, Va., Los Angeles, Calif. and New London, Conn. The report included no data and no information on evaluation design or methods. The developers stated that compared to a control group, the self-report survey findings indicated that participants learned the program information, were able to achieve the goals they set and found the process of setting and attaining goals easier than they expected. The developers also reported that compared to a control group, students who participated in *GOAL* had better school attendance and reported a decrease in alcohol use, frequency of getting drunk, smoking cigarettes, other drug use, and violent and other problem behaviors.

A member of the Life Skills Center conducted a small focus group study (N=20) to ascertain the participants' impressions of the program. This nonrepresentative sample involved sixth-grade students in three middle schools in Richmond. The majority of the students were African American (91 percent) and female (53 percent). The focus groups lasted one 50-minute class period in each of the three schools. The focus groups determined whether the students' perceptions of four variables considered important in the program: planfulness, ability to identify strategies to realize the plan, ability to identify obstacles that interfere with planfulness and ability to identify obstacles and supports to implementing effective strategies.

The interviewer concluded that participation in *GOAL* enabled the students to think positively about their future and increased the students' perception of the number of skills they possessed to achieve their goals. According to the students, these conditions were not present prior to *GOAL*. The interviewer believed that the *GOAL* program accelerated cognitive developmental processes and enabled the students to think more abstractly. The students liked the 50-minute workshop format that included individualized attention, varied and fun activities and ample opportunity to participate.

The interviewed *GOAL* students did not anticipate positive futures for their other peers. Although the *GOAL* students felt that they had learned valuable strategies for ignoring obstacles, they lacked confidence in their abilities to use those strategies in the face of non-supportive adults. This sense of powerlessness came from an inability to predict adult expectations, being in an environment not conducive to learning, and being repeatedly told about how "bad" youth were. The students perceived a great deal of racial prejudice that would interfere with their ability to succeed.

Critique

GOAL is similar in many respect to Botvin's life skills training program that has demonstrated effectiveness in reducing high-risk behaviors. *GOAL*'s developers reported positive student behavior and attitudes regarding alcohol, tobacco and other drug use, violence and school attendance as a result of participation in the program. Description of the evaluation design and methods plus lack of data presentation limit conclusion about *GOAL*'s effectiveness.

Evaluation Contact

Todd C. O'Hearn
Department of Psychology
University of South California
Los Angeles, CA 90089-1061
PH: (310) 470-4063 / FAX: (213) 746-5994

Good Touch/Bad Touch

Program Description

The *Good Touch/Bad Touch* program is a child abuse prevention program for preschool-aged to sixth-grade students. Developed in 1984 in Georgia, the goal of the program is to prevent or stop child abuse and to reduce the trauma associated with it. The curriculum includes accurate, age-appropriate information and helpful strategies to limit emotional and sexual abuse. Modifications have been made for the developmentally delayed.

The preschool program contains four 20-minute lessons. The K-2 program contains four 30-minute lessons. In the first session children define child sexual abuse through a story and by playing a simple game designed to help them understand when something "went wrong" (sexual abuse). The second session includes a film about sexual abuse prevention. Children also learn a simple song about body safety. Session three discusses who sexually abuses children and presents two stories in which child characters are role played by two dolls. The story teaches that sexual-abuse victims are not bad and the abuse is not their fault. Beginning in the third grade, the program addresses physical abuse and bullying. The fifth- and sixth-grade curricula address sexual harassment, physical and emotional abuse and neglect.

Staff development focuses on implementing the curriculum in an effective manner. Additional content includes reporting requirements; the signs and symptoms of child abuse; the dynamics between the offender and the child victim; characteristics of immediate and long-term impact on the child; the role of drugs and alcohol in abuse; and working with the family. Training includes a combination of lecture, classroom demonstrations, films, role modeling and discussion.

Over 100 of Georgia's 186 school systems and a number of school districts in other states have implemented *Good Touch/Bad Touch*. To date, approximately 2500 teachers, school counselors, school administrators, child protective services employees, mental health counselors, preschool and Head Start teachers have received training in the program.

Services Available

Training and certification, curricula, support materials including parent booklets, coloring books, a toll-free help line and anger management workshops are available.

Implications for Practice

Recent estimates of child sexual abuse show that as many as 40 million people, or about one in six Americans, may have been sexually abused as a child. Short-term negative effects include fear, depression and hostility. Long-term effects include poor self-esteem, adolescent pregnancy and substance abuse. Based on the estimated numbers of children affected and the negative effects associated, there is a need to develop prevention and intervention programs. *Healthy People 2000* objective 7.4 seeks to reduce child abuse.

Audience		
	P	✓
	K[3]	✓
	4[6]	✓
	M	
	H	
	K[12]	
	S	✓

Locale		
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	U	
	S	
	M	✓

Level		
	Cl	✓
	B	
	D	
	Co	

Components		
	C	✓
	St	✓
	Pe	
	Pa	✓
	M	
	P	
	Sk	
	Se	

Emphasis		
	K	✓
	A	
	N	
	B	

Pam Church
Director
Prevention and Motivation Programs, Inc.
P.O. Box 1960
659 Henderson Dr., Suite H
Cartersville, GA 30120
PH: (800) 245-1527 / FAX (770) 607-9600

Good Touch/Bad Touch

✓	E	Design
	Q	
✓	I	Analysis
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	QI	Data
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✓	O	
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Evidence of Program Effectiveness

The program evaluation involved kindergarten children from rural, low-income families in central Georgia. The children ranged in age from 5-7 and 50 percent were African American. Children were randomly assigned to one of two groups. The program group received the *Good Touch/Bad Touch* program which involved three half-hour sessions presented on three consecutive days with approximately 20 children in each session. The control group were read stories and saw a film – none of which were related to sexual abuse – in three sessions over the three days.

A trained interviewer, who was unaware of whether children were in the program or control group, assessed ninety children individually, at pre-intervention, 71 (79 percent) for a posttest three weeks later and 68 (76 percent) for follow up a month later. Two other researchers conducted both the control and intervention programs. Both individuals had substantial experience working with children and had implemented the sexual abuse prevention program together and individually on multiple occasions.

The dependent measures were three aspects of the prevention program: differentiation between good and sexually-abusive touches, basic knowledge about coping with sexual abuse and application of such knowledge to specific situations. To measure differentiation, children responded to a series of 10 pictures of young children interacting with an adult or adolescent. Five pictures presented good touches (e.g., a hug) and five presented inappropriate touching (e.g. a man touching a child between the legs). Knowledge about coping with abuse consisted of asking each child five questions: Is it okay to ever break a promise? Do you think children should always obey grown-ups? If a person forces or tricks you into a bad touch, should you tell? Do you think that sometimes grown-ups trick children into a bad touch? Do you think that children should decide with whom they want to share their bodies? The test for application of knowledge consisted of two parts – direct and generalization tests.

Both tests depicted two stories of sexual abuse, one involving an adult and one involving an adolescent. Each story was read to the child and followed by six questions concerning whether the abuse was wrong and what the child should do. The direct test and the generalization test differed in that the direct test depicted scenes discussed in the program whereas the story in the generalization test was not in the program. The experimenter recorded each child's responses on a standardized form.

Initial analyses performed on the dependent variables indicated that sex and race did not produce significant effects and did not interact with the group factor (treatment versus control); therefore these factors were dropped from the primary analysis. The post-intervention and follow-up data were analyzed using a one-way analysis of covariance with the pre-intervention score serving as the covariate. All the variables measured showed significant improvement ($p < .05$ or $p < .01$) in children's ability to recognize abuse and to know what to do if it occurred.

Critique

Evaluation results from this small sample suggest that children as young as kindergarten age can learn knowledge and skills for the prevention of sexual abuse. Future research needs to address issues concerning maintenance and actual application of the skills. Because external, trained specialists taught the program, program fidelity was not an issue but generalizability of the results in "real world" classrooms remains untested. Teachers in a variety of settings have used the curricula, but there are no reports of evaluations of their use.

Evaluation Contact

Rex Forehand, PhD
Department of Psychology
University of Georgia
Athens, GA.
PH: (706) 549-0541

GRADS

Program Description

Graduation, Reality and Dual-Role Skills Program (*GRADS*) is an in-school family and consumer sciences (formerly home economics) education program for pregnant and parenting adolescents, both male and female, in seventh to 12th grades. *GRADS'* primary goal is to keep teens in school while they learn parenting skills and explore vocational goals. *GRADS* was developed in 1980-81 in a response to the growing teen pregnancy and parenthood problem in Ohio and funded by the Ohio Department of Education, Division of Vocational and Adult Education.

The goals of the program are to 1) increase the likelihood that participants will remain in school during pregnancy and after childbirth; 2) increase the likelihood that participants will graduate; 3) insure healthy mothers and babies; 4) prepare participants for work and economic self-sufficiency; 5) help participants set goals that will allow them to balance work and family; and 6) reduce subsequent pregnancies during adolescence. Key strategies of the program include: enrolling participants for academic credit for up to two years, providing teacher resources, and providing student materials that include activities for building participants' ability to resolve problems associated with parenting, poor self-esteem and lack of finances. A *GRADS* advisory committee links the program with community agencies. Teachers have annual opportunities for professional development.

GRADS classes meet daily or a minimum of two hours a week. The curriculum emphasizes practical reasoning and communication skills. When needed, *GRADS* teachers supplement classroom activities with home visits. Many *GRADS* programs have in-school child care programs and transportation grants.

The U.S. Department of Education validated *GRADS* in 1990 as part of its National Diffusion Network and revalidated it in 1995. As of October 1994, 505 school districts in 85 of Ohio's 88 counties offered *GRADS* in at least one school in 1993-94. In addition, 94 school districts, representing 129 programs, in 13 additional states used GRADS. The schools, including vocational, are located in urban, suburban and rural communities.

Services Available

The Ohio Department of Education produces an 88 module *Adolescent Parent Resource Guide*. The Department annually offers two-day "train the trainer" workshops in Ohio. Ten certified trainers offer training in five additional states. The Department has available information brochures and implementation packets and can provide technical assistance.

Implications for Practice

Although the U.S. teen birth rate has declined somewhat in recent years, teenage pregnancy and parenthood remains a significant social problem. Early parenthood often begins a cycle of dependency that results in poorer health and school achievement for both parents and children. The U.S. Government Accounting Office estimated in 1994 that early parenthood costs U. S. society $34 billion annually. Part of that cost is due to the increased incidence of low-birth weight babies among adolescent mothers. Teen parents are less likely to be married, are less likely to graduate from high school, are more likely to have additional babies, and more likely to be poor. *Healthy People 2000* objective 14.5 calls for reducing low-birth weight babies to no more than 5 percent of live births. The *GRADS* program addresses many of the critical factors that result in improved outcomes for teen parents and their children.

Audience	
P	
K[3]	
4[6]	
M	✓
H	✓
K[12]	
S	

Locale	
R	
U	
S	
M	✓

Level	
Cl	✓
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Co	✓

Components	
C	✓
St	✓
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Sk	✓
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Emphasis	
K	✓
A	✓
N	
B	✓

Sharon G. Enright
Project Director
Family and Consumer Sciences
Ohio Department of Education
Division of Adult and Vocational Education
65 South Front St., Room 909
Columbus, OH 43215-4183
PH: (614) 466-3046 / FAX: (614) 644-5702

GRADS

	E	Design
✓	Q	
✓	I	Analysis
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	B	
	D	
	C	
	M	
	QI	Data
✓	Qn	
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Evidence of Program Effectiveness

Several measures have assessed the effectiveness of the *GRADS* program over several years. In 1993, two-day visits at four *GRADS* sites assessed program implementation and the satisfaction of students and their families using the Attkinson client evaluation of services form and interviews. Information obtained from a survey of training session participants in 13 states who did not adopt the program helped determine barriers to adoption.

In 1994, an impact study used pre/posttests of parenting competencies over a six-month period with 148 students who were and were not program participants. The test, adapted from the Ohio Competency Analysis Profile examined four factors — adjustment to parenting, knowledge of child development, knowledge of child care and knowledge of family relationships. A randomly selected stratified sample of Ohio *GRADS* teachers administered the tests. All *GRADS* teachers receive annual surveys asking about student enrollment, classroom activities, student status after birth, birth weight of babies and other program outcomes.

Using data from these and other assessments, *GRADS* has shown to:

- Keep students in school until graduation. Enrollment data revealed that Ohio *GRADS* has a retention rate of 85 percent compared to retention rates of pregnant and parenting teens of 67 percent to 91 percent in other states.

- Increase participants' knowledge of positive parenting practices. The gains were modest but consistent. However, evaluators presented no tests of statistical significance or comparative data.

- Increase participants' likelihood of delivering a healthy baby. In 1995, 79.6 percent of Ohio *GRADS* participants received prenatal care in the first trimester of pregnancy, compared to the national rate of 53.1 percent among pregnant teens. *GRADS* mothers gave birth to fewer low-birth weight babies than did other Ohio mothers 18 or younger who did not participate in the program (7.6 percent versus 10.3 percent).

- Reduce the number of subsequent pregnancies within two years. Between 1994-95, 11.9 percent of *GRADS* participants had a subsequent pregnancy compared to nearly 50 percent nationally two years postpartum.

Critique

The *GRADS* program shows considerable promise of keeping pregnant and parenting teens in school, reducing the number of low-birth weight babies born to participants and reducing the likelihood of subsequent adolescent pregnancies among participants – especially when compared to national data. The evaluators did not discuss comparability of participants and nonparticipants in the various studies. Longer-term, follow up measures would strengthen the short-term findings.

Evaluation Contact

Richard Hill, William L. Hull
Principal Investigators
The Ohio State University Research Foundation
Department of Home Economics Education
1960 Kenny Road
Columbus, OH 43210-1063
PH: (614) 292-1993

Healthy for Life

Program Description

Douglas Piper, Pacific Institute for Research and Evaluation, and D. Paul Moberg, University of Wisconsin, developed *Healthy for Life* with funding from the National Institute on Drug Abuse. The program uses the social influence theory to address five high-risk health behaviors of middle school students including nutrition habits, tobacco, alcohol and marijuana use, and sexual behavior. The original program had two versions: an intensive 12-week course delivered in seventh grade and a four-week course delivered sequentially in sixth, seventh and eighth grades.

A premise of the program is that young adolescents' perceptions of the social norm in a situation strongly influences their behaviors. Four social networks are significant: family, peers, school and community. In *Healthy for Life*, these social networks communicate clear, consistent messages that complement the classroom health curriculum. The program's goal is for adolescents to have the social skills they need to handle situations when others want them to participate in high-risk behaviors.

The curriculum contains approximately sixty 40-minute lessons containing one to four activities. Each four week segment culminates in a "special event" designed to positively reinforce the unit. In the sequential version delivered over three years, the units are cumulative as well as developmentally appropriate. For example, the sixth-grade segment heavily covers tobacco while the eighth-grade topics include dating and riding in a car with an impaired driver. The curriculum uses eight principle teaching strategies: social inoculation, peer leaders, emphasis on short-term effects, involvement of parents and community, public commitments, media, health advocacy by the students and awareness of peer norms. There are no tests, quizzes or grades but *Healthy for Life* uses a variety of "incentives" such as t-shirts and calculators to motivate positive performance.

Each class elects three peer leaders who assist the teachers by leading discussions, facilitating small group activities, and participating in role plays. Peer leaders receive training from *Healthy for Life* educators.

The family component includes parent orientation sessions, informational mailings to homes and parent interviews conducted by students as homework assignments. The community component includes establishing an *Healthy for Life* task force and a media campaign.

Services Available

Healthy for Life's organizers do not sell the curriculum, but negotiate with interested schools to provide training for faculty, parents and community members. A three-day, on-site training is approximately $4,000, plus travel costs, but the training cost varies depending on the school's needs.

Implications for Practice

Adolescence is a time of testing and exploration filled with both risk and opportunity and teenagers often make decisions for social reasons. At a later time they may analyze costs and benefits of a particular choice. *Healthy for Life* is a comprehensive program that recognizes important social networks and uses those networks to provide helpful information and skills that address five priority health areas identified by the Centers for Disease Control and Prevention. As a comprehensive program, *Healthy for Life* addresses several *Healthy People 2000* objectives in the areas of nutrition, tobacco, alcohol and other drugs, unintentional injuries, family planning, HIV infection and sexually transmitted diseases.

Audience		
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	M	✓
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	K^{12}	
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Locale		
	R	✓
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	S	✓
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Level		
	Cl	✓
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	D	
	Co	✓

Components		
	C	✓
	St	✓
	Pe	✓
	Pa	✓
	M	✓
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	✓
	N	✓
	B	✓

Monica J. King
Program Coordinator
Pacific Institute
617 North Segoe Road
Madison, WI 53705
PH: (608) 231-2334 / FAX: (608) 231-3211

Healthy for Life

	E	Design
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Evidence of Program Effectiveness

Between 1987-91, 2,278 sixth-, seventh- and eighth-grade students from 21 elementary, middle and junior high schools in 17 small cities and towns (69 percent) or rural areas (27 percent) in Wisconsin, participated in a field test of the program. The sample was 51.5 percent female and 95.6 percent White. Nineteen percent of the population was lost at follow up over the course of four years.

Schools resisted random assignment and 11 schools self-selected the age appropriate intervention (daily, 43-minute sessions, four weeks, same cohort, sixth, seven and eighth grade) and 11 selected the intensive intervention (daily 43-minute sessions, 12 weeks, seventh grade). Within each group, four schools were randomly selected to serve as comparison schools resulting in a randomized control group design nested within two self-selected treatment options. There were no significant initial differences in alcohol, tobacco and marijuana use or health attitudes among the schools.

Data assessed program fidelity, looked for unanticipated outcomes. Process measures included classroom observations, student and teacher interviews, student and parent feedback questionnaires and teacher logs. A questionnaire, administered at baseline and annually, measured program outcomes related to nutrition, substance use and sexuality behaviors. Carbon monoxide levels were used to validate self-reports of smoking.

The data revealed small effect sizes on all variables. By ninth grade, students in the intensive version were significantly more likely to eat more meals in a week, significantly less likely to use cigarettes and scored lower on an overall scale of substance use. Males were less likely to use smokeless tobacco, than students in control schools. Students in the age-appropriate intervention scored higher on alcohol and smokeless tobacco use than controls, suggesting short-term negative effects. Trend data for the intensive intervention indicated immediate negative effects characterized by increases in high-risk behaviors, but positive effects by the following year. Differences between intervention and control groups on measures of food choices, sexual intercourse, alcohol use and marijuana use were not significant.

Substance use by prior cohorts of students was a strong predictor of substance use among subsequent cohorts up to four years later.

The perceptions of students in intensive schools were that substance use by their peers, in general, and best friends, in particular, was significantly lower than the perceptions of students in control schools. Students in intensive schools reported fewer offers of drugs. Students in both programs reported increased levels of communication with parents about health behaviors compared to controls.

Teachers, students and parents all responded positively and strengths they noted included salience of topics to adolescents, co-teaching by program educators and classroom teachers and the parent-adolescent communication activities. The evaluators noted that some teachers had difficulty with teaching methods that are outside the mainstream, especially using peer leaders, parent involvement and the health advocacy events where students interacted with the community. To a lesser extent, this was also the case for cooperative learning methods, social inoculation techniques and replacing grades with an incentive system. Female students liked the intervention better than males, and peer leaders liked it better than non-leaders. Implementation of the community component varied widely, with the greatest success in communities with existing organizations that had strong leadership, well established identities, and clear missions consistent with the program's goals. Community events focused primarily on substance abuse prevention and general health. Examination of links between quality of intervention and outcomes yielded no consistent or interpretable results.

Critique

The study report provided no information on the reliability of the questionnaire. The sample represented a fairly restricted population and the results might not be generalizable to ethnically diverse communities.

Evaluation Contact

Douglas Piper, PhD
Pacific Institute
617 North Segoe Road
Madison, WI 53705
PH: (608) 231-2334 / FAX: (608) 231-3211

High/Scope Perry Preschool Project

Program Description

David Weikart and teachers from Perry Elementary School in Ypsilanti, Michigan, a suburb of Detroit, developed the *High/Scope Perry Preschool Project* in 1962. With the support of an activist principal, Perry School served as a community center as well as a school. The program targeted children between the ages of 2-5 years who were living in poverty and at high risk of school failure. The program has since expanded to elementary schools and developed materials for adolescents.

Drawing on the child development ideas of Jean Piaget, the preschool program actively involves children in ten key developmental experiences: creative representation, language and literacy, social relations and personal initiative, movement, music, classification, sequencing, numbers, space, and time. Each category fosters specific characteristics. For example, under *social relations and personal initiative*, children learn to make and express choices, plans and decisions; solve problems encountered in play; express feelings in words and deal with social conflict. Children are active participants who can initiate their own learning activities and exert some control over their lives. Rather than asking questions that test children's specific knowledge of letters or numbers, teachers engage children with questions such as, "What happened? How did you make that?" and "Can you show me?" These strategies develop a sense of initiative, responsibility and independence as the children grow. To increase parent involvement in their child's learning, families receive weekly home visits.

Teachers receive systematic training and support in program application from technical assistance centers nationwide as well as at the annual conference of the National Association for the Education of Young Children. Developers recommend that a trained curriculum specialist be on staff to provide hands-on workshops, observation and feedback as well as follow-up sessions to no more than 25 teachers at a time. In recognition of excellence in the prevention of mental-emotional disabilities and the promotion of mental health, the program was awarded the 1987 National Mental Health Association Lela Rowland Prevention Award.

Services Available

High/Scope Press offers a variety of materials including books, software, teaching guides and videos. Prices range from $5 to $588. Two-, three- and five-day training sessions are offered. A graduate program, public policy and research, and preschool classroom internships are also available.

Implications for Practice

In the United States, an estimated 15.3 million children, or one out of five American children, still live in poverty. Childhood poverty correlates with school failure which increases the likelihood of substance use and abuse, unplanned pregnancy, violence and adult poverty. In 1983, the National Commission on Excellence in Education warned in *A Nation at Risk* that the nation's schools needed to take steps to improve educational outcomes if the U.S. was to remain competitive in a global economy. In 1989, the first goal adopted by the National Education Goals was that by the year 2000, all children in America will start school ready to learn. Three objectives address that goal: 1) all children will have access to high-quality and developmentally appropriate preschool programs that help prepare children for school; 2) every parent in the U.S. will be a child's first teacher and devote time each day to helping their children learn, and parents will have access to the training and support they need; and 3) children will receive the nutrition, physical activity experiences and health care needed to arrive at school with healthy minds and bodies, and to maintain the mental alertness necessary to be prepared to learn. The *High/Scope Perry Preschool Project* has addressed the first two objectives for over 30 years with well documented success. Objective 8.3 of *Healthy People 2000* calls for access to high-quality and developmental-appropriate preschool programs for all disadvantaged children.

Audience	
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Dr. David P. Weikart
President
High/Scope Educational Research Foundation
600 N. River Street
Ypsilanti, MI 48198-2898
PH: (313) 485-2000 / FAX: (313) 485-0704

High/Scope Perry Preschool Project

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Evidence of Program Effectiveness

The *High/Scope Perry Preschool Project* has conducted a longitudinal study to follow the lives of 123 children who were randomly assigned to either the program group (N=58) or no-program group (N=65). Approximately 28 children began each year, phased in over a five-year period. Selected children resided in the Perry Elementary School neighborhood, came from families of low socioeconomic status and exhibited low intellectual performance but no evidence of organic disability. All of the children were African American. Nearly half were from single parent families, at a time when the national average for single parent black families was approximately one third. The children attended preschool for two-and-a-half hours, five days a week and received a high-quality active learning program at ages 3 and 4. Of the 128 originally selected, four moved away and one died. Most children attended for two years. Program children and their mothers also received weekly 90 minute home visits from the classroom teacher. Data was collected on both groups annually from age 3 through 11 and again at ages 14, 15, 19 and 27. Data included standard measures such as the Stanford-Binet Intelligence Scale, Illinois Test of Psycholinguistic Abilities and Pupil Behavior Inventory, one-and-a-half to two hour interviews, school records, crime and other social service records.

Attrition and missing data across all measures was less than 10 percent at all data collection points. The most recent measurement at age 27 interviewed 117 people (95 percent). Six people were lost to follow-up: two males in the program group could not be found: both had been interviewed at age 19 and had records of school suspensions and a few arrests. Also, four females in the no-program group could not be interviewed. Two were sisters who had not been interviewed at either age 15 or 19. The other two were deceased, both victims of drug-related murders.

The study revealed several important findings. Thirty-five percent of the no-program group had been arrested five or more times by age 27 and 25 percent at least once for drug dealing - compared with 7 percent of the program group in both categories. Out of wedlock births were high in both groups but far fewer in the program group, 57 percent vs. 83 percent, respectively. Seventy-one percent of the program group completed 12 or more years of school compared with 54 percent of the control group. Significantly more program females completed high school compared to no-program females (84 percent vs. 35 percent) but program males completed slightly less schooling than their counterparts. Twenty-nine percent of the program group, compared with 7 percent of the no-program group, earned at least $2,000 a month. Eighty percent of the no-program group received welfare as an adult, compared with 59 percent of the program group.

Critique

The High/Scope Perry Preschool Study is a well-designed and rigorous study that has produced strong evidence regarding the value of high-quality, active learning programs for young children living in poverty. The developers estimate that the program returns $7.16 for every dollar invested, cuts in half participants' crime rate through age 27, significantly increases their earnings and contributes to stable family groups. Although these findings yield compelling arguments to support high-quality preschool programs, the developers note that such programs are only one part of the solution to address the problems of violence, substance abuse and unplanned pregnancy; other social policy strategies will be needed. Affordable housing, universal access to health care, effective job-training programs, reduction of institutional racism and improved educational opportunities at all levels are essential.

Evaluation Contact

Lawrence J. Schweinhart, PhD
Chair
Research Division
High/Scope Educational Research Foundation
600 N. River Street
Ypsilanti, MI 48198-2898
PH: (313) 485-2000 / FAX: (313) 485-0704

I Can Problem Solve

Program Description

The *I Can Problem Solve* (*ICPS*) program is both a preventive and rehabilitative program to help children, in preschool to grade six, resolve interpersonal problems and prevent antisocial behavior. The program, developed more than two decades ago by George Spivack, PhD and Myrna Shure, PhD, uses a cognitive approach that teaches children how to think, not what to think. Students learn that behavior has causes, that people have feelings and that there is more than one way to solve a problem. The program especially targets behaviors such as impatience, aggression, over-emotionality and social withdrawal.

ICPS is available for three developmental levels – preschool, kindergarten and primary grades, and intermediate elementary grades. The *ICPS* curriculum teaches children problem-solving skills through games, stories, puppets, illustrations and role-plays. Students and teachers use problem-solving talk when situations arise in the classroom. The program includes suggestions for integrating program concepts into age-appropriate academic subjects. In addition to consequential thinking, older children ages 9-12 learn steps for reaching a goal with patience, while overcoming obstacles.

ICPS developers recommend using the program daily, or at least three times a week for several months with reinforcement throughout the year. Research suggests that students who receive two years of training have more lasting effects than do those receiving only one year of training. All children in a class can benefit from the program, although children who are considered at high risk for school failure might need additional specialized, intensive group work.

Various sites across the country, both regular and special education classrooms, have implemented ICPS. Sites include Philadelphia, Dade County, Fla., and Chicago. The National Mental Health Association, the American Psychological Association and the National Association of School Psychologists have each recommended the program or given it awards.

Services Available

ICPS provides three curricula: Preschool (59 lessons); Kindergarten and Primary Grades (83 lessons) and Intermediate Elementary Grades (77 lessons). Order from Research Press, Dept. 12, P.O. Box 9177, Champaign, IL 61821. Each costs $39.95, plus shipping and handling. The Mental Health Association of Illinois has a demonstration video. The program also offers a workbook and audiocassette for parents called *Raising a Thinking Child*. On site training can be arranged.

Implications for Practice

Good mental health refers not only to the absence of mental disorders but also to the ability of an individual to negotiate the daily challenges and social interactions of life without experiencing cognitive, emotional or behavioral dysfunction. Children who have poor social skills and are unable to solve problems effectively are at risk for violence, depression and suicide, and substance abuse. Priority Area 6 of *Healthy People 2000* addresses the mental health needs of the nation and objective 6.2 seeks to reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17. Although the rate of suicides has declined since 1987, suicide attempts by adolescents have continued to climb. Programs such as ICPS, which are implemented early in a child's life, can help prevent risk behaviors from developing and provide skills that are useful both inside and outside the classroom.

Audience	
P	✓
K^3	✓
4^6	✓
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S	✓

Locale	
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M	✓

Level	
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Components	
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Sk	✓
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Emphasis	
K	✓
A	✓
N	
B	✓

Myrna B. Shure, PhD
Allegheny University
Department of Clinical/Health Psychology
Broad & Vine, Mail Stop 626
Philadelphia, PA 19102-1192
PH: (215) 762-7205 / FAX: (215) 762-4419

I Can Problem Solve

	E	Design
✓	Q	
✓	I	Analysis
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Evidence of Program Effectiveness

This program has produced statistically and clinically significant positive results in numerous studies over two decades. A longitudinal study supported the National Institute for Mental Health followed 562 low-income, African-American children, who lived in the inner city, from kindergarten for up to five years. Starting in kindergarten, children experienced one of three *ICPS* training arrangements or served as controls: Group 1 - kindergarten only (trained by teacher); Group 2 - kindergarten and first grade (trained by teacher); Group 3 - kindergarten (trained by teacher); first grade (trained by mother); and Group 4 - never trained controls. At baseline, the evaluation found no significant differences between the control and program groups.

The measures, developed by the principal investigator, assessed children's ability to think of alternative solutions to problems and consequences to interpersonal acts. Teachers, peers and independent observers rated the children using standardized forms. Observations took place from kindergarten through fourth grade. In addition, outcome measures in third and fourth grade included students' performance on standardized reading and math tests.

The behaviors most affected, by the program, were impulsiveness, social withdrawal, poor peer relationships and lack of concern for others. The skills with the greatest impact were identifying alternative solutions and predicting consequences.

Attrition was high. By the end of second grade, 162 boys and 162 girls remained. By Year 5, 252 students remained in the program group. Although gender differences appeared in years three and four of the follow up, by year five, both boys and girls who received two years of training scored better than the controls on all three factors rated by independent observers – impulsiveness, inhibition and total behavior problems. Boys trained by both the teacher and mother did better in predicting consequences than other boys. Although there was some disappearance of behavioral impact one and two years following training, the youngsters trained by their teachers in both kindergarten and first grade emerged at the end of fourth grade as the most well-adjusted group overall.

In another study, more children who received the training in pre-kindergarten were rated as "adjusted" than those not exposed (71 percent vs. 54 percent, $p>.01$). In addition, 22 of 44 impulsive children improved behaviorally compared to eight of 39 impulsive children in the control group. These gains lasted through first grade, when the study ended. A study of fifth- and sixth-graders exposed to the program found that two years of the program reduced negative impulses, negative behaviors, and improved positive behaviors. However, the behavioral gains were weaker than for younger children.

Effective implementation of the program requires a cooperative school environment and administrative support. Starting with teachers who volunteer usually results in other teachers asking for the program. The longitudinal study had problems with control group follow-up, due in part to several teachers resenting not being allowed to participate in the *ICPS* training and refusing to complete the behavior rating scales for their students.

Nonetheless, program results have been replicated in demonstration sites in a variety of urban, suburban and rural settings, with different ages (through age 12) and racial and ethnic groups and with children from different socioeconomic strata.

Critique

ICPS has undergone several evaluation studies. Studies of pre-kindergarten and kindergarten children have shown *ICPS* to significantly decrease impulsiveness, increase the ability to find alternatives and predict consequences, and decrease overall problem behaviors. These findings, measured by independent observers with a high inter-rater reliability, were greatest in the first year after exposure, but held up for at least five years, especially among children who had two years of exposure. A study of fifth- and sixth-graders exposed to the program found less dramatic results.

Evaluation Contact

Myrna B. Shure, PhD
Allegheny University
Department of Clinical/Health Psychology
Broad & Vine, Mail Stop 626
Philadelphia, PA 19102-1192
PH: (215) 762-7205 / FAX: (215) 762-4419

Increasing Bicycle Helmet Use In Michigan

Program Description

Increasing Bicycle Helmet Use in Michigan is a school-based program that targets middle school students. The intent is to motivate students to wear helmets when riding bicycles. The Michigan Department of Health developed the program with the help of an injury control incentive grant from the Centers for Disease Control and Prevention in 1988.

The program has two possible levels of intensity. Both versions incorporate a single lesson for use in either sixth or seventh grade meant to supplement the Michigan Model health education curriculum. The lesson covers facts about bicycles and head injury, reasons why people do not use helmets and a discussion of overcoming barriers to use.

To change peer norms in favor of helmet use, both levels of the program provide public service announcements featuring professional sports figures for use on local television stations or school's closed circuits, posters for display around the school, and colorful brochures for students and their parents. The pilot program provided bike helmet discount coupons.

In addition, the high-intensity program features distributing free helmets and an all-school assembly featuring professional athletes talking about the value of helmets.

Services Available

Free materials available include classroom lessons, separate bicycle helmet brochures for parents and children and public service announcement videos.

Implications for Practice

Head injury is the most common cause of death and disability in bicycle-related crashes accounting for 62 percent of bicycle-related deaths and 67 percent of all bicycle-related hospital admissions. *Healthy People 2000* objectives 9.11 and 9.13 address reducing head injuries and wearing helmets, while objective 9.18 calls for injury prevention instruction as part of a comprehensive school health program.

Helmets are a proven intervention that can reduce the incidence and severity of head injuries caused by bicycle crashes. Middle school youth, especially boys, are particularly vulnerable. Increased bicycle helmet use among 10- to 14-year-olds would not only reduce the rate of death and injury in this group, but helmet-wearing early adolescents could also serve as role models for younger children.

Audience	
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Locale	
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Components	
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Heather Festerling
Center for Health Promotion and Chronic Disease Prevention
Michigan Department of Community Health
3423 N. Martin Luther King Jr. Blvd.
Lansing, MI 48909
PH: (517) 335-9519 / FAX: (517) 335-8395

Increasing Bicycle Helmet Use In Michigan

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Evidence of Program Effectiveness

Six middle schools in Oakland County, Mich., participated in either the low- or high-intensity version of this program. One school implementing each level of intensity was from an urban, suburban and rural area. The combined enrollment of the schools was approximately 3,100 students. Selected schools had already implemented the Michigan Model for Comprehensive School Health Education, which contains general injury control elements. Random assignment was not possible because too few schools agreed to participate. A significant obstacle to school recruitment was the requirement that schools provide home phone numbers of their students for use in the pre/post-intervention telephone surveys.

One week before the program, evaluators from the Kercher Center for Social Research at Western Michigan University telephoned 427 randomly selected households having students enrolled in the participating schools. The 49-item telephone survey asked parents about their children's bicycle riding frequency and helmet use, about the parent's attitudes toward helmet usage, and about bicycle-related injuries requiring medical care. Three to four weeks post-intervention, evaluators called another 414 randomly selected households. All households selected contained at least one child between the ages of 10-14 who rode a bicycle at least occasionally. The post-intervention survey also included questions concerning the parents' and students' exposure to the intervention program. Other measures included teacher surveys, informal observations by school personnel and follow up with stores regarding redemptions of helmet discount coupons.

Parents reported an increase of helmet ownership from 5 percent prior to the program to 18.5 percent after the program. Nearly the entire increase was due to the helmet giveaways at the high-intensity schools. Although helmet ownership in the low-intensity schools did not increase significantly, the proportion of helmet-owning students reported to wear their helmets at least 50 percent of the time did increase. Sporadic observations by school personnel, however, revealed no changes in helmet behavior.

Furthermore, post-intervention surveys found that almost 40 percent of the parents in the low-intensity programs and 30 percent of parents in high-intensity programs still believed that their children did not need bike helmets. Local bicycle shops reported redemptions of less than four of the discount coupons two months after the intervention. About one-third of parents remembered receiving the bike helmet brochure and discount coupon in the mail. Those parents who remembered receiving the materials were more likely to talk with their children about the importance of wearing a helmet. Teachers' assessment of the student assemblies, curriculum guide and helmet distribution was generally favorable. Most teachers stated that they spent between 15 to 30 minutes on the subject and half used at least one of the videos provided.

Critique

The *Increasing Bicycle Helmet Use in Michigan* uses several strategies to increase helmet use. In the high-intensity schools, the program achieved its short-term goal of at least 10 percent of students wearing helmets at least half the time. The weak evaluation design does not allow a determination of which program components contributed to the increase. No one measured whether or how often any public service announcements appeared on the local television channels. Parents and teachers reported on students' helmet usage, but students were never asked for self-reports. Instead of the informal observations reported, formal direct observations could contribute valuable data to a similar study. As implemented the program was expensive and required considerable time to coordinate. Since the development of this program, helmet manufacturers have designed more colorful and better looking helmets that are easier to adjust and less expensive. Thus many of the program materials are now out of date.

Evaluation Contact

Beth Bacon
Michigan Bicycle Helmet Advisory Committee
Center for Health Promotion
Michigan Department of Public Health
3423 N. Martin L. King, Jr. Blvd.
PO Box 30195
Lansing, MI 48909
PH: (517) 335-8398

Jeffco Middle School Life Science Project

Program Description

The *Jeffco Middle School Life Science Project* began in Jefferson County School District, Colo., in 1984. With funding support from the National Science Foundation, science teachers, content specialists and science education faculty developed a yearlong life science course for the seventh and eighth grades. The goals of the program are to enable students to: 1) understand the structure and function of the various systems of the human body; 2) understand the decisions necessary to improve a variety of health behaviors; 3) understand basic ecological principles, and 4) understand and develop solutions for environmental issues and problems. A fundamental assumption of the development team was that students should study fewer topics in greater depth. By spending more time on each subject, students would better understand concepts and their experimental basis, and would acquire skills for learning, thinking and solving problems. Program components include laboratory activities, readings and questions. The curriculum suggests adaptations for gifted students as well as those with learning disabilities.

The seven units included in the curriculum are cells and genetics, body structure, body systems, body changes, body control, foods and digestion, ecosystems and ecology. The learning cycle developed by Karplus serves as the framework for each unit. The learning cycle involves three phases: exploration, concept formation, and application. In the exploration phase, students typically carry out an experiment or investigation that introduces the phenomena and experiences that lead to concept development in the second phase. The application activity or discussion in which students apply the concept demonstrates the usefulness of the concept and reinforces learning through additional exposures and personal use. Student assessment includes a series of analysis questions ranging from simple recall to comprehension, analysis, and some synthesis. Implementation of the curriculum requires a laboratory facility equipped with flat top tables, storage space and a minimum of one sink.

The U.S. Department of Education's Program Effectiveness Panel reviewed the curriculum and accepted it for distribution through the National Diffusion Network in 1989. National distribution began in 1990. Materials have since been revised and updated based on current scientific research.

Services Available

School text with integrated activities, teachers' guide and resource book with test item file, implementation guide and teacher training sessions are available. Call Kendall/Hunt Publishing Company of Dubuque, Iowa at 1-800-258-5622 for current prices. Developers recommend 40 hours of staff development presented at intervals throughout the year in all-day workshops and sessions after school.

Implications for Practice

The national science content standards for middle school students include personal health and environmental issues as well as understanding risk and benefit concepts. These standards provide a solid foundation on which to address many objectives identified in *Healthy People 2000*. Although science educators and health educators strive to achieve somewhat different ends, by working together, life science teachers and health educators can meet both science and health education standards, resulting in increased understanding and application. Such collaboration seems a likely strategy to achieve *Goal 5* of the *National Education Goals* as well as to provide students with many of the critical tools needed to make healthy decisions and establish healthy habits.

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Emphasis		
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Judy Capra
Project Co-Director
Jeffco Middle School Life Science
Wheat Ridge Middle School
7101 West 38th Ave.
Wheat Ridge, CO 80033
PH: (303) 467-1184

Jeffco Middle School Life Science Project

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Evidence of Program Effectiveness

The evaluation spanned two years and involved 654 seventh graders in Jefferson County junior high schools. Participants were primarily white (74 percent to 95 percent) with Hispanics representing the largest minority (<1 percent to 22 percent). The sampling pool included junior high schools in Jefferson County in which all life science teachers had received training and had taught the curriculum the previous year but had not been involved in developing assessment instruments. Using stratified sampling to represent the diversity of socioeconomic status within the district, researchers selected from the eligible schools four to test the intervention the first year and three the second year. In each selected school, all seventh grade science teachers participated in the study. Control schools were selected from Jefferson County and two neighboring districts to match the socioeconomic composition of the experimental schools. Within the control schools, life science classes were selected to match the mean achievement of experimental group classes. Interviews of teachers in the control schools ensured that they taught the major topics included in the experimental curriculum.

Tests consisted of four locally developed pretests and four locally developed posttests of life skills concepts and factual knowledge. A panel of educators screened the initial pool of items for ethnic and gender bias. A pilot test eliminated additional items. Reliability of the 21-25 item multiple choice tests ranged from .76 to .91. Students completed the pretest early in September of each year. They completed one posttest every nine weeks during the school year. Comparisons of the mean experimental posttest scores to the mean control posttest, using pretest scores as covariates were made for each year. The mathematics subtest of the Iowa Test of Basic Skills (ITBS) served as an independent measure of achievement.

A treatment by gender by achievement model was employed for each dependent measure using the pretest as a covariate. To test for interactions of treatment with ability, students were assigned to low, medium, and high-achievement groups on the basis of ITBS mathematics scores. A second analysis examined interactions of treatment with the teacher's ability.

For this analysis, the covariates were science pretest and mathematics achievement. In each phase effects were tested at alpha = .001, .01 and .05.

Analysis of the data indicated that students exposed to the *Jeffco Middle School Life Science Project* significantly improved their conceptual and factual knowledge ($p<.001$) more than students taught with a traditional curriculum. The experimental group's improved performance was consistent across ability levels, teachers, and gender. The students in the high achievement group out performed controls by a larger margin than low-ability students, but the performance of low-achieving students still exceeded the control group. Attrition was moderately low and did not compromise the strong results of the second year testing.

Critique

The evaluation was conducted between 1987-89 using a quasi-experimental research design with rigorous and appropriate statistical controls to adjust for minor initial differences between experimental and comparison groups. Reliability and validity measures offered credible evidence that the program increased students' acquisition of life science concepts and facts. Many of those concepts address health knowledge and behaviors. The second year's findings found that as teachers become more experienced with the curriculum, achievement increased even more. The results of the study suggest that the curriculum would be effective even in districts where the proportion of low-achieving students is considerably higher than in Jefferson County.

Evaluation Contact

Harold Pratt
Executive Director for Science and Technology
Jefferson County Public Schools
1829 Denver West Dr., Bldg. 27
Golden, CO 80401
PH: (303) 273-6559

Kansas LEAN

Program Description

The Kansas Department of Health and the Work Group on Health Promotion and Community Development at the University of Kansas together developed the *Kansas LEAN School Health Project* in 1992. The goal of the project is to reduce the risk for chronic diseases, including heart disease and some cancers, among children in fourth through sixth grades using four program components: nutrition education, increased opportunities for physical activity, modified school lunches and community involvement. Health services staff provides clinical assessments of students' cholesterol levels, percent body fat, height and weight.

The primary intervention consists of hiring registered dietician consultants to spend 20-30 hours a week with each district. The consultants provide on-site training and technical assistance to teachers, physical educators, and food service staff. They also work with community members to make community-wide changes that support the mission of the project. The classroom nutrition education component of the program is the American Cancer Society's *Changing the Course*. The curriculum's goals are to increase students' consumption of a variety of fruits and vegetables, high-fiber foods and foods lower in fat. Small group activities, including food tasting, complement the curriculum. Teachers receive six hours of in-service training prior to implementation. Recommendations for changes in policies and school practices such as parents bringing low-fat snacks for class parties reinforce health education in the classroom. The consultants provided food service staff with assistance in records' management, preparing foods to reduce dietary fat, assessing nutritional content of vendor-supplied items, planning menus and ordering ingredients. The school food service staff then prepares snacks that complement the curriculum and modifies school lunches to reduce the fat content to 30 percent or less of calories.

To encourage more physical activity during the school day, the project recommends fitness stations in classrooms. Stand-alone classroom fitness modules include games, music and dance. The project's physical education curriculum involves implementation in the classroom and includes strategies that increase physical activity and introduce stretching routines to prevent injury.

Community health councils advise the school and link school activities with local grocery stores, recreation centers, restaurants and families. The program involves planning a variety of onetime fitness and nutrition activities for the community including educational workshops, health fairs and family fitness/fun walks.

Services Available

The *Kansas LEAN Project* will be replicated in six additional Kansas communities from 1995 to 1998. Technical assistance is available to other communities.

Implications for Practice

Modifiable risk behaviors for chronic diseases such as heart disease, cancer and diabetes are established early in life. By age 12, an estimated 40 to 60 percent of U.S. children have at least one risk factor for cardiovascular disease. Several objectives of *Healthy People 2000* address reducing these risks (sections 15, 16, 17). A comprehensive approach involving classroom teachers, physical educators and food service staff offers a promising strategy for promoting positive health habits. Such a multifaceted program must address the constraints placed on school food service programs, the need for teachers to have nutrition knowledge and interactive teaching skills, and physical educators' abilities to provide sufficient opportunities for students to engage in vigorous activity on a regular basis. For children to internalize lifelong habits of healthy eating and physical activity requires reinforcement over a number of years. The *Kansas LEAN Project* provides a model that might provide insight into establishing a comprehensive school health program.

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K^{12}	
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Emphasis	
K	✓
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B	✓

Judy Johnston, MS, RD/LD
Director
Bureau of Chronic Disease and Health Promotion
Kansas Department of Health and Environment
30 S. Market 6th Floor
Wichita, Kansas 67202-3802
PH: (316) 337-6050 / FAX: (316) 337-6023

Kansas LEAN

	E	Design
✓	Q	
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Evidence of Program Effectiveness

A qualitative, case study design evaluated the program in two dissimilar communities in Kansas. One community was relatively urban (pop. 42,303) and served 6,000 students in 15 schools. Cooks prepared school meals for the district at four centralized kitchens. The other community was small (pop. 1,400) and rural, serving 400 students. Cooks prepared meals on-site. The evaluation took place over a two-year period. In one district, 74 fourth-grade students participated in the program and 62 fourth-grade students at two other schools within the district served as comparisons. In the other district, all fifth-grade students (N=34) received the program. There was no comparison group.

The Amateur Athletic Union's (AAU) physical fitness assessment measured strength, muscular endurance, cardiorespiratory endurance and flexibility before and after program implementation. At posttest, the larger school district found a statistically significant difference between students in program and control classes in the time to run one mile. The percent of students in the rural setting who performed at or above the standard increased from 18 percent at pretest to 29 percent at posttest, but the increase was not statistically significant perhaps due to small sample size.

Schools' menus were analyzed using *Nutrition Four*, a computerized menu analysis program. Baseline levels of percent calories from fat ranged from 38 percent to 41 percent. By the end of the second year (1993-94) the percent of calories from fat fell to the target level of 30 percent. However, total calories ranged from 767 KC to 830 KC, which was above the targeted level of 750 KC. A review of students' records showed that participation in the school lunch program remained relatively constant in the two communities during the study while the cost of the lunch program increased by less than 5 percent.

Instruments that accompany the American Cancer Society's *Changing the Course* curriculum for lower and upper elementary school students assessed the nutrition education component. The instruments are paper/pencil self reporting measures of student's nutrition knowledge, attitudes and behaviors. The percentage of youth who answered the nutrition knowledge questions correctly increased significantly from pretest to posttest ($p<.0001$).

Cholesterol screenings and skinfold measurements were intermediate assessments of students' risk for cardiovascular disease. The invasive procedure required to conduct cholesterol screenings limited the number of students who participated, thus yielding too small a sample for meaningful data analysis. Skinfold measurements lacked inter-rater reliability, limiting their usefulness for data analysis.

To measure the community intervention component, project evaluators counted the number of community changes, defined as new programs, policies, or practices in the school or community, made by the Project to reduce students' risk of cardiovascular disease. They documented over 250 community changes in the two project sites. A survey of community members about the value of the project included only community members who were involved with the project, making any findings questionable.

Critique

The *Kansas LEAN Project* attempted to reduce youth's risk for chronic disease through systemic programs that included community coalitions, school food service staff, and classroom and physical education teachers. Positive findings included increases in students' knowledge and large numbers of new projects initiated in the community as a result of the project. The evaluation presented several methodological concerns that limited other conclusions about the program's effectiveness – small sample sizes, biased community samples, lack of a comparison group for one program site, and difficulty with some measurements. Given the scope and complexity of the project and of the evaluation attempted, the project might provide others with suggestions for developing, evaluating, and implementing a community-wide, multicomponent intervention that includes coalition building.

Evaluation Contact

Kari Harris, MS
Work Group on Health Promotion
Department of Human Development
University of Kansas
Lawrence, KS 66045
PH: (913) 864-0533 / FAX: (913) 864-5281

Mediation in the Schools

Program Description

The *Mediation in the Schools* program, developed by the New Mexico Center for Dispute Resolution (NMCDR), Albuquerque, N.M., promotes the positive resolution of conflict in schools. More than 185 New Mexico schools have implemented the program, including urban, multi-cultural and rural schools with Native-American and Hispanic populations. The program consists of three components: conflict management curriculum for the classroom; adult modeling of mediation in conflict resolution; and training of student mediators to provide mediation services to other students.

The K-6 curriculum consists of classroom activities that can be integrated into social studies, language arts or counseling. In fourth to sixth grade, selected students receive 12 to 15 hours of training by student mediators, school mediation staff and faculty coordinators. Student mediators perform on-the-spot dispute resolution when a conflict occurs on the playground. Teachers also receive training, then model the mediation process, problem-solving techniques and principles. At the secondary level, a group of teachers and students who have demonstrated leadership, whether "positive" or "negative," become conflict mediators after 12 to 15 hours of training, conducted by the program's staff. In secondary-level program schools, a faculty coordinator schedules mediation sessions upon receiving a referral of a student-to-student or student-to-faculty dispute.

The NMCDR has applied the principles of mediation to the resolution of gang disputes and disputes among groups of different nationalities. The mediation process also is for issues related to suspension and truancy and disputes between students and teachers or students and parents.

Services Available

The NMCDR created the National Resource Center for Youth Mediation to provide materials, training and technical assistance on *Mediation in Schools* and other related programs. The Nation Resource Center offers several curricular materials, including grade-related texts, and four-day summer institutes at basic and advanced levels in New Mexico every summer. It also provides on-site training and technical assistance for a fee. The cost of materials ranges from $15-$120. Training costs approximately $475 per person plus travel expenses.

Implications for Practice

Interpersonal violence among U.S. school-age children and youth represents a major problem. The 1995 *Youth Risk Behavior Survey* found that more than 15 percent of high school students had been in a physical fight on school property. *Healthy People 2000* objective 7.9 calls for reducing incidences of physical fighting among adolescents aged 14-17 by 20 percent. One strategy to create a safer atmosphere at school and in the community is to implement conflict resolution and mediation training. If adolescents can learn to avoid violence as a means of solving problems, alternative nonviolent patterns might be extended through life. The *Mediation in Schools* targets students and teachers in elementary and secondary schools.

Audience	
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Emphasis	
K	✓
A	✓
N	✓
B	✓

National Resource Center for Youth Mediation
New Mexico Center for Dispute Resolution
620 Roma NW, Suite B
Albuquerque, NM 87102
PH: (505) 247-0571 / FAX: (505) 242-5966

Mediation in the Schools

	E	Design
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Evidence of Program Effectiveness

An evaluation of the program conducted during the 1986-87 school year collected data from students and teachers. A similar study conducted in 1993-94 collected data from school administrators, program coordinators, counselors and students in a sample of schools. Study participants included those in schools with the program and those without. In program schools, both trained and untrained students completed surveys.

In the 1993-94 study, 104 of 200 schools contacted (52 percent), representing 63 elementary, 33 middle and eight high schools, provided basic demographic information. Reporting schools estimated that approximately 3,000 students and 1,600 staff members had been trained in program. Coordinators reported more than 2,300 mediations and more than 1,500 known agreements. Coordinators reported that 800 teachers used the curriculum to some extent, 88 percent at the elementary level.

The program appeared to be "owned" by the students. Students were described as being more in control and empowered, as well as exhibiting higher self-esteem. Coordinators and administrators reported decreased levels of violence since the introduction of the program, despite the fact that only about half of the teachers model program principles.

Twenty schools, 10 program and 10 non-program, received the entire survey package. Nine program and seven non-program schools responded. Of the 16 schools, 12 were elementary, representing 167 teachers, while only four schools were middle/high schools representing 67 teachers. Teachers in the program schools perceived less violence and hurtful behaviors among students, while teachers in non-program schools felt that students were exhibiting more violence than in the previous year. Program teachers believed that the program was effective in teaching students alternative, positive dispute resolution strategies and in decreasing levels of violence at school.

Two instruments compare students' experiences with and perceptions about the program. Students trained as mediators received an eight-item survey, while untrained students received a 10-item survey. Two hundred fifty trained students in nine program schools, 300 untrained students in nine non-program schools and 470 untrained students in nine program schools for a total of 1,320 students responded. Trained and untrained students differed in their level of awareness of constructive conflict resolution strategies and in their attitudes toward conflict and feelings about themselves.

The student survey used in the 1986-87 study demonstrated evidence of reliability and face validity. It compared pre/posttest score changes for trained mediators in elementary and middle schools with students in non-program schools. Trained mediators scored better than controls on problem solving and conflict resolution skills, self concept and commitment to school.

Critique

The data, while promising, includes no measure of levels of violence and disciplinary actions before and after program implementation. Evaluators presented no evidence of comparability of program and controls in either study. These research design limitations and lack of statistical analysis limits the ability to draw conclusions about program effectiveness.

Evaluation Contact
Susan Lee Carter, PhD
P.O. Box 67
Cerrillos, NM 87010
PH: (505) 424-0244

Multnomah County (OR) School Based Health Centers

Program Description

Multnomah County, Oregon, has included line item funding for school-based health centers since 1986. By 1995, seven high schools, two middle schools and an elementary school had such Centers. Staff at each Center include a community health nurse, nurse practitioner or physician assistant, mental health consultant and senior office assistant. The elementary school's staff also includes a health educator and an outreach worker. The Centers provide treatment for minor illnesses and injuries, routine physical exams, immunizations, health promotion programs, crisis and mental health counseling, and reproductive health services.

Mental health services include individual, group and family counseling for problems such as depression, suicidal thinking, family conflict, substance abuse, sexual abuse, eating disorders and to identify conflict. Whenever possible, families are involved in counseling. For specialized physical or mental health services or long-term treatment, students receive referrals to other Multnomah County Health Centers and to physicians in the community.

Beginning in 1992, the high school Centers began dispensing condoms along with counseling. Center staff may write prescriptions for but not dispense other forms of birth control. Other reproductive health services include counseling, testing and treatment for sexually transmitted diseases, HIV counseling and testing, family planning counseling, and abstinence counseling. Health promotion programs include *Students Today Aren't Ready for Sex* (*STARS*), and a locally adapted middle-school version of the curriculum *Postponing Sexual Involvement.*

Centers are open every day school is open, with hours extending before and after school. Most students make appointments for services during free periods, and before or after school. Students without appointments see the school nurse who might handle the problem or refer the student to the Center or another medical resource.

Although Centers may not, by state law, require parental consent for students over age 15, Center staff encourage students to involve their parents in health care decisions whenever possible. Each Center involves parents through an advisory committee that reviews policies and other issues of concern at that school site.

Services Available

The Multnomah County Health Department can offer expertise and guidance in the development of school-based health centers related to many operational and policy issues.

Implications for Practice

Healthy People 2000 objective 21.4 calls for reducing financial barriers to clinical preventive services. By providing county funds, Multnomah County has demonstrated a model for providing clinical preventive and treatment services to students. Those served tend to be at higher risk for adverse health outcomes than those who do not use the services, demonstrating the potential for impact of such Centers.

Audience	
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K[12]	✓
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B	✓

Jill A. Daniels, CHN
School Based Health Centers Program
Multnomah County Health Department
426 SW Stark, 160/9
Portland, OR 97204
PH: (503) 248-3674 / FAX: (503) 306-5847

Multnomah County (OR) School Based Health Centers

	E	Design
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Evaluation of Program Effectiveness

A 1994 study of the high school, school-based health Centers in Multnomah County involved telephone interviews with a random sample of parents, a census survey of 11th-grade students in schools with Centers, and a survey of school staff in those schools.

The parent study used a case-control method to ensure adequate representation of parents of students who did and did not use a school based health center (SBHC). The telephone interviews assessed what parents thought and knew about SBHCs. Whether or not their children attended schools with Centers, the majority of the 326 parents interviewed supported the Centers and wanted expanded services. A great majority of all parents agreed that Centers should provide mental health and reproductive health counseling services. Eighty-two percent of the parents of users and 73 percent of the parents of nonusers (nonparticipants at schools with as well as students in schools without Centers) wanted SBHCs to provide birth control. Although 81 percent of parents of Center users reported talking to their children about experiences with the Center, parents would like more communication between parents and the Center staff.

Of the 1,119, 11th-grade students who completed the health survey, 60 percent had ever used a SBHC. Compared to nonusers, students who had used the SBHC had more financial need for services and reported more health problems and risk behaviors. Nearly 80 percent of sexually active students who reported seeking reproductive health services used a SBHC.

The evaluators adapted the survey for local use, drawing on instruments developed by the National Adolescent Health Resource Center and the Centers for Disease Control and Prevention. However, they did not report any reliability or validity measures for the instrument or name the instruments they drew from.

Survey results of school staff mirrored the parents' responses. The vast majority of teachers, counselors, administrators, and support staff believed that Centers provided a needed service, recommended expanding services, and wished for more communication with Center staff. School staff reported referring students primarily for general health issues, but also referred students for personal problems and reproductive health care and counseling.

This cross-sectional research design and the lack of pretest measures or a control group prevented the study from assessing the impact of the school based health centers on students' risk behaviors or on pregnancy rates. The Centers had operated for eight years prior to the study and no baseline data was available. Without controls, pre/post-comparison data, even if available, could not control for history or time effects.

Critique

The study lacked outcome data for students receiving services. The parent survey compared responses of parents whose children did and did not have access to SBHC services. The student survey included only students with access to services and provided descriptive information about those who used the services compared to those who did not. Parents, students and school personnel all responded favorably.

Evaluation Contact
Dr. Barbara Glick
Principal Investigator
Program Design and Evaluation Services
Multnomah County Health Department,
School Based Health Centers
426 SW Stark, Eighth floor
Portland, OR 97204
PH: (503) 248-3663, ext. 28271

Oregon School Based Health Centers

Program Description

Oregon established a school-based health center (SBHC) in 1985 and is one of the states that has seen the most significant growth in the number of these clinics. As of 1996, state funds supported 14 of the 29 SBHCs statewide. SBHCs offer students easy access to a wide range of health services. The majority of visits are for general medical services, such as the treatment of acute illnesses and injuries, or for the management of chronic conditions. Some centers offer reproductive health services, including diagnosis and treatment of sexually transmitted diseases, family planning information and pregnancy tests. Mental and emotional health services include individual counseling, support groups and referrals to other community resources. Health promotion is an integral part of all health center services. Students learn how behavior effects health and the role of personal responsibility in maintaining health. In addition, staff members provide classroom and community presentations on topics such as smoking, HIV/AIDS and nutrition.

An office assistant and a nurse or a nurse practitioner routinely staff the health centers. Other health professionals, such as mental health or alcohol and other drug counselors have on-site office hours for assessment, education or primary care services in some centers. The primary care provider usually sees students on an appointment basis, but drop-in visits are possible. A few centers are exploring summer operations, evening hours or combining efforts with other community-based service integration models.

Each SBHC has an advisory board made up of parents, teachers, students, health care providers and community leaders. SBHCs encourage family involvement and provide information about health center services to parents. Parents are welcome to call or visit the health center.

Services Available

The Oregon Health Division can offer technical assistance in starting and funding SBHCs. *Oregon: Making the Grade* and other materials offer advice on organizing SBHCs. The Division also has an instrument SBHCs can use for continuous quality improvement.

Implications for Practice

Healthy People 2000 objective 21.4 calls for reducing financial barriers to clinical preventive services. By using state funds, Oregon has established SBHCs that provide clinical preventive and treatment services in many locations throughout the state. Those served tend to be at higher risk for adverse health outcomes than those who do not use the services, demonstrating that SBHCs have the potential to reduce disparities in access to health services.

Audience		
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School Based Health Centers
Technical Assistance Office
Oregon Health Division
800 NE Oregon St., #21, Suite 825
Portland, OR 97232
PH: (503) 731-4021 / FAX: (503) 731-4083

Oregon School Based Health Centers

Design: [ ] E [✓] Q

Analysis: [✓] I [ ] G [✓] B [ ] D [ ] C [ ] M

Data: [ ] QI [ ] Qn [✓] B

Type: [ ] F [ ] S [✓] O [✓] P

Evaluation of Program Effectiveness

A study to evaluate the impact of the SBHC program on students' health used a prospective observational design with cross-sectional sampling of students in nine schools. Students in participating schools completed an Adolescent Health Survey in the 1990 fall (baseline) and 1992 fall (follow up). A process evaluation component included two schools with SBHCs established at least a year before baseline data collection and three schools with new clinics that had opened within five months matched with four comparison schools. Eighty-three percent of eligible students completed the survey. Teachers administered the confidential and anonymous survey. Items came from existing national and regional health questionnaires with additional items specific to Oregon's health program. In addition, evaluators collected information from providers using structured telephone interviews. The impact evaluation included data from only the three schools with new clinics and their matched schools.

Measures of health service utilization revealed that of 3,667 students in the five schools with SBHCs, almost 50 percent had used the SBHC at least once. Ninety percent of those who had used it reported trusting the clinic staff and agreed that the SBHC made access to health care easier. Twelve percent had no other place to go for health care. Compared to those who used outside health care providers, users of SBHCs had higher percentages of risk indicators, although only differences in emotional health indicators reached significance. Three times as many sexually-active students sought care from outside providers as from SBHCs, perhaps because of the limits on the reproductive health services SBHCs provide.

Aggregate data from all three sets of schools used for the impact evaluation found no difference between students in schools with SBHCs and in those without. However, one of the three program schools – the one with the most community support and most comprehensive program – did show effects. Students in that one decreased substance use, improved reproductive health attitudes and reduced sexual activity more between baseline and follow-up measures than did those in the control school.

A second study compared the Centers for Disease Control and Prevention's *Youth Risk Behaviors Survey*'s 1995 data for students in schools with and without SBHCs and for users and nonusers of SBHC services where the services existed. Participating schools volunteered, not a random sample, which limits the generalizing of the results. Survey results indicated that the number of students using SBHCs is increasing and that minority students, older students, and students living in lower socioeconomic areas were more likely than others to use SBHCs. Students reported using SBHC services because of easy access, finances and protection of privacy.

In schools with SBHCs, more students had received complete immunization; care for emotional, personal or substance abuse problems; care for sexually transmitted diseases; and reproductive health services. Students who used SBHCs had higher levels of abuse, drug use and sexual activity than did nonusers. They had lower rates of unprotected sexual activity and more concern about HIV infection.

Critique

In the first study, it was unclear why impact measures included only the newly opened clinics. Neither study provided information about reliability or validity of measures used, except to say that many items came from nationally-used surveys. The budget cutbacks and associated reductions in SBHC services during the first study probably limited the SBHCs' impact and might have accounted for the findings. Both studies found that SBHCs served students at higher risk for adverse health outcomes than those not served. Such findings demand caution when comparing outcomes of students using and not using SBHCs. Change scores thus might be better measures of impact than cross-sectional data.

Evaluation Contact

Tammy Alexander
Adolescent Health Coordinator
Oregon Department of Human Resources
Oregon Health Division
800 NE Oregon St., #21, Suite 825
Portland, OR 97232
PH: (503) 731-4021 / FAX: (503) 731-4083

Parents & Adolescents Can Talk

Program Description

The *Parents and Adolescents Can Talk* (*PACT*) program is a community-based, sexuality and communication education program for fifth- through 12th-grade students and their parents. Created in Gallatin, Mont. over community concerns about teenage sexual activity, *PACT* strives to encourage the postponement of premature sexual activity by "building resiliency" using a value-oriented curriculum for youth and their parents. The premise of *PACT* is that the family should play a central role in the development of healthy sexual attitudes and responsible sexual behavior among preadolescents and adolescents. Montana State University assisted with development and conducted an evaluation of the program, while funding came in part from a five-year, demonstration project through the Adolescent Family Life initiative of the U.S. Department of Health and Human Services. In 1992, *PACT* became a nonprofit organization.

PACT consists of independent modules for preadolescents (fifth and sixth grade), adolescents (seventh to ninth grade) and older youth (tenth to 12th grade). In each session students and their parents meet, together and separately, and have assignments to work on between sessions. The final session occurs four months following the completion of the other sessions. The program's modules and home activities focus on self esteem, parent/youth communication, assertiveness, decision making, knowledge of physiology and reproductive health and values and attitudes toward sexuality. A separate module addresses training adult and youth facilitators to implement the program. Each module includes behavioral objectives, a facilitator guide and copy masters of handouts and transparencies.

The preadolescent curriculum consists of nine, nearly two-hour sessions plus an extra session for parents only. It provides a forum for parents and youth to improve communication skills and share factual information about the mental, physical, emotional and relationship changes and includes information on sexually transmitted diseases and sexual abuse prevention.

The adolescent curriculum consists of eight, two-and-a-half hour sessions. It addresses effective communication behaviors, assertiveness, decision making, guidelines for sexual behavior and knowledge of physiology and health issues, including sexually transmitted diseases and consequences of teen pregnancy.

The older youth curriculum consists of seven, two-and-a-half hour sessions. It addresses the same content as the adolescent curriculum, from a knowledge base and issues that face older youth and their parents. The peer facilitator training, intended for older adolescents and parents who have completed one of the other modules, consists of four, approximately three-hour sessions. Recent additions to *PACT* include a substance abuse and fourth- and fifth-grade youth module. *PACT* also provides a school-based program alternative for each of the first three modules.

Services Available

In-school and community-based modules cost $45 each. The peer-facilitator module costs $25. Other items include several slide sets that range from $16 to $85 and the "*Let's Talk*" video which costs $15.

Implications for Practice

The sexual behavior of teenagers is one of six critical health issues facing adolescents, according the Centers for Disease Control and Prevention. *Healthy People 2000* recognizes the role families can play in reducing risk behaviors and objective 8.9 calls for increasing to at least 75 percent the proportion of people aged 10 and older who have discussed issues related to health-related behaviors, including sexual behaviors, with family members on at least one occasion during the preceding month. The *National Education Goals* also call for increased parental involvement in promoting their children's social, emotional, and academic growth. The 1996 *Executive Summary of the National Education Goals Report* indicates no discernible progress in achieving this goal. *PACT* offers training to enhance communication between youth and their parents about sexual attitudes, values and behaviors.

Audience	
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Co	✓

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Emphasis	
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B	✓

Joye B. Kohl, EdD
Project Director
Parents and Adolescents Can Talk
5727 Blackwood Rd.
Bozeman, MT 59715
PH: (406) 586-4743

Parents & Adolescents Can Talk

Design: [ ] E [✓] Q

Analysis: [✓] I [ ] G [ ] B [ ] D [ ] C [ ] M

Data: [ ] QI [✓] Qn [ ] B

Type: [✓] F [ ] S [ ] O [ ] P

Evidence of Program Effectiveness

The most recent *PACT* evaluation took place during 1987-89 in 22 cities in Montana. It involved 183 preadolescents, 255 adolescents and 417 parents. The majority of the youth had received no previous formal education about communication or sexuality. Parents were most likely to be in their thirties, married and living in a household with an annual income of $30,000 or more.

The evaluation strategy involved a pretest given during session one, a posttest given in the next to the last session, and four-month follow-up test given during the last session in each module. Rosenberg's Self-Esteem scale assessed changes in self-esteem. Other items measured sexuality knowledge and the amount of time spent discussing sexual issues with parents. In addition, five items asked about a progression of sexual behaviors, from holding hands to sexual intercourse. The authors presented no data about test reliability or validity. Evaluators collected insufficient control group data and in-school program data to make comparisons.

The evaluation found significant increases in knowledge of sexuality and reproductive health for preadolescents, adolescents and parents at the posttest, but much of the gain disappeared by the four-month follow-up measure. Increases in self-esteem measures held up for both groups of youth through the four-month follow-up. Among preadolescents, higher knowledge and more talking with parents correlated with lower rates of sexual activity. There were no increases in adolescents' more intimate sexual behaviors. Among adolescents there was a positive correlation between higher self-esteem and a lower incidence of intimate sexual behaviors. Parents in both groups significantly increased the amount of time they talked to their adolescent children about sexuality at post test. Only parents of adolescents maintained the increase at the four-month follow-up.

Critique

The program increased adolescents' self esteem, and parents reports of communication with their children about sexuality. Those effects might contribute to both preadolescent and adolescent youth avoiding the most intimate sexual behaviors that could result in pregnancy and sexually transmitted disease. The program has much to offer intact families with a good foundation. It does not address hard-to-reach youth and dysfunctional families.

The evaluation has several design flaws that the evaluators acknowledged. Lack of comparison groups, high attrition, and problems associated with self-report data all dictate a cautious approach to ascribing findings to the program. In addition, participants self-select, so selection bias is quite possible. Data from the in-school program was unavailable.

Evaluation Contact

Rodney M. Cate, PhD
Child and Family Studies
University of Arizona
1600 E. University Blvd.
Tucson, AZ 85721

Positive Adolescent Choices Training

Program Description

The *Positive Adolescent Choices Training (PACT)* program is a school-based, violence-prevention program for high-risk African American students between the ages of 12 and 16. Developed in 1989 by researchers from Wright State University in collaboration with the Dayton Public Schools, the program is based on social learning and anger control theories. It assumes that adolescents who lack skills in such areas as communication, negotiation, and problem-solving have a limited range of alternatives with which to solve interpersonal problems.

Teachers refer participants to the program based on perceived skill deficiencies in peer relations, behavior problems – especially aggression – and a history of violence, victimization or exposure to violence. The program is structured as a "club" where students develop the rules for expected behavior, select team names and colors and choose incentives for which they would like to work. In order to cast the program in a positive light, it is promoted as focusing on skill and leadership development and health and safety promotion rather than on the prevention of negative behaviors. Small groups of 10-12 students meet twice a week for one, 50-minute class period for a semester. Doctoral-degree level psychology students from Wright State University facilitate group exercises that are culturally sensitive. One component of the program uses videos to demonstrate the social skills of giving negative feedback ("Givin' It"), receiving negative feedback ("Takin' It") and negotiation ("Workin' It Out"). Each skill is broken down into well-defined behavioral components that youth practice in small groups. A second component addresses anger management and teaches youth to recognize anger triggers, to understand their anger responses, to think through the consequences of their responses and to call upon techniques to control their anger. The third component of the program informs youth about the dynamics of violence and dispels myths about violence risk.

Services Available

The three videos cost $250 (plus shipping and handling) and include a program guide. Preview videos are available on loan for one day at no charge. The program guide includes a program overview and rationale; implementation, training and behavior management procedures; suggestions for parent involvement and training; and evaluation methods. The package also includes sample forms, evaluation instruments, student handouts and worksheets and a list of resource material. Extra copies of the *PACT* program guide cost $17.95 each. Wright State University offers a five-day, train-the-trainer institute as well as on-site consultation visits and a companion parent training program.

Implications for Practice

A disproportionate number of African-Americans live with violence, both as victims and perpetrators. According to the Centers for Disease Control and Prevention, homicide is the leading cause of death for African-American males ages 15 to 24. Particularly troubling is the sharp rise in the homicide rates - from a rate of 48.64 per 100,000 in 1980 to a rate of 128.82 per 100,000 in 1992. Several *Healthy People 2000* objectives call for reducing violent and abusive behaviors among adolescents (objectives 7.1, 7.3, 7.6, 7.7, 7.9, 7.10, 7.11). Teaching specific communication and negotiation skills that reduce conflict might decrease the incidence of assault and homicide in the school and community. *PACT* begins with sound conceptual models and empirically tested methods and renders them acceptable, relevant and accessible to ethnic minority youth by using culturally compatible content and activities.

Audience	
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K[3]	
4[6]	
M	✓
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K[12]	
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Locale	
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U	✓
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M	

Level	
Cl	✓
B	
D	
Co	

Components	
C	✓
St	✓
Pe	✓
Pa	✓
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P	
Sk	✓
Se	

Emphasis	
K	
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N	
B	✓

Betty R. Yung, PhD
PACT Project Director
Wright State University
9 N. Edwin C. Moses Blvd.
Dayton, OH 45407
PH: (513) 873-4300
FAX: (513) 873-4323

for materials:
Research Press
Dept. 204
P.O. Box 9177
Champaign, IL 61826
PH: (217) 352-3273
FAX: (217) 352-1221

Positive Adolescent Choices Training

	E	Design
✓	Q	
✓	I	Analysis
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	QI	Data
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Evidence of Program Effectiveness

A 1992-93 study assessed *PACT*'s processes and outcomes in a middle school that had one of the highest rates of violence-related suspensions and expulsions in the district. The urban middle school was in a system serving approximately 28,000 students, of whom approximately 63 percent were African-American and most of whom were economically and educationally disadvantaged. The study involved 91 program students and 78 comparison students who were referred to the program but were unable to participate. The report presented no analysis of comparability of students in the two groups.

Outcome measures included pre/post ratings (Likert scale) by teachers and parents or other significant adults on measures of pro-social and anger management skills. Neutral, independent observers rated videotapes of students without knowing whether they had received the program. On the tapes, students demonstrated the three target skills in a role play scenario acted out with an adult facilitator. In addition, students rated themselves on their confidence and ability to perform the targeted social skills. Evaluators examined school disciplinary records before and after the program looking for incidences of physical aggression, verbal intimidation or aggression or other misbehavior. They also examined juvenile court records for two years following the program to track charges of violence-related offenses, criminal acts or status offenses brought against the program or control youth.

PACT students demonstrated a 50 percent reduction in physical aggression at school; showed behavior improvement during the course of training which was maintained beyond participation in the program; and had more than 50 percent fewer overall and violence – related juvenile court charges and a lower per-person rate of offending than students who did not receive training.

Critique

PACT appears to successfully reduce violence and criminal behaviors among high risk African-American youth. This effect, while lessening somewhat, is maintained over time. Compared to a control group, students who participated in the program had fewer behavioral disturbances in school and a lower incidence of arrest in the community.

The *PACT* researchers acknowledge several evaluation design limitations including no random assignment, reliance on a single long-term follow-up measure (juvenile court records), a comparison group that received no programming; no structured way to capture data on victimization, and no testing of the efficacy of a particular component vs. a different component (e.g., effects of using an incentive system vs. no material rewards). A small sample size in only one location limits generalization of findings. The evaluators provided no evidence of reliability or validity for assessment tools and no inter-rater reliability of videotape reviewers. Reliance on doctoral students to facilitate the small groups might limit the program's potential for widespread replication.

Evaluation Contact

Betty R. Yung, PhD
PACT Project Director
Wright State University
9 N. Edwin C. Moses Blvd.
Dayton, OH 45407
PH: (513) 873-4300 / FAX: (513) 873-4323

Primary Mental Health Project

Program Description

The *Primary Mental Health Project* (*PMHP*) began in 1957 as a school-based early detection and intervention program for pre-kindergarten through third-grade students who were experiencing minor school adjustment difficulties. Since then more than 1,000 school districts throughout the United States and Canada have adopted the program, which now serves more than 40,000 children annually. *PMHP* seeks to deter later adjustment difficulties by early recognition and referral. The program's focus is strengthening children's adaptive abilities and encouraging them to seek and utilize successful strategies for dealing with life's stressors. *PMHP* most often serves children with multiple, long-standing problems.

In schools adopting *PMHP*, teachers learn to use the Classroom Adjustment Rating Scale (CARS) that includes 41 problem behaviors linked to acting out, shyness/anxiety and learning difficulties. Teachers refer identified students to "child associates" for services. The child associates are carefully trained paraprofessionals who receive training in a variety of subjects, including child development, confidentiality, communication with children, and the meaning of children's play. The school district's mental health professional (school social worker or school psychologist) supervises the child associate. In weekly meetings, the child associate consults with the teacher in order to monitor each child's progress. Generally child associates see children individually for approximately 30 minutes once a week for several months (10 to 15 sessions per semester). Individual needs dictate the number and length of contacts. The teacher, parents, child associate, and mental health professional jointly establish expected outcomes for each student. Schools adopting *PMHP* need to provide child associates with a separate area within the school, stocked with a variety of items that children can use to express themselves through creative play.

In one cost-effectiveness study, a single contact for a child averaged less than $20 and the average annual cost was less than $500 per year per child. Recently, the Primary Mental Health Project added a shorter, six-week, 12-session program called Planned Short-Term Intervention (PSI) for children in grades 2-5. PSI associates help each child deal with specific behaviors such as aggression, shyness, inattentiveness and/or restlessness.

In 1984, *PMHP* received the Lela Rowland Award from the National Mental Health Association as an exemplary model for preventive school-based mental health services.

Services Available

PMHP, Inc. is a not-for-profit organization that offers assessment instruments, scoring, training, evaluation, videotapes, and books. Contact them for a current price list.

Implications for Practice

Because adults are often reluctant to recognize when they need assistance when under duress, *Healthy People 2000* Objective 6.8 identifies the need to increase the number of individuals who seek help in coping with personal and emotional problems. A significant proportion of children also experience school adjustment problems or other behavioral difficulties. Longitudinal studies have found that children with mental disorders or adjustment problems are at increased risk for abusing substances, later delinquent behaviors, and mental health referrals. A large percentage of youth experiencing emotional problems go unidentified. By recognizing these needs before they become entrenched and providing help in accessing services, *PMHP* encourages help-seeking behavior early. By using well-trained and supervised paraprofessionals, *PMHP* is a cost-effective method of extending mental health and primary prevention services to children in the primary grades.

Audience		
	P	
	K^3	✓
	4^6	✓
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	K^{12}	
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Locale		
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	U	
	S	
	M	✓

Level		
	Cl	✓
	B	
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Components		
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	St	✓
	Pe	
	Pa	
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	
	A	
	N	
	B	✓

Deborah Johnson
Director of Community Services
Primary Mental Health Project
685 South Avenue
Rochester, NY 14620-1345
PH: (716) 262-2920 / FAX: (716) 262-4761

Primary Mental Health Project

	E	Design
✓	Q	
✓	I	Analysis
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	QI	Data
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Evidence of Program Effectiveness

In 1983, program evaluators reviewed seven consecutive annual cohorts of program participants that ranged in size from 206 to 464. The first cohort began receiving services under *PMHP* in 1974. For each cohort, teachers screened all primary grade children and using the *PMHP* criteria, referred those at risk for school maladjustment to the program. All referred children were evaluated using four screening tests at the time of referral and at the completion of the intervention. Teachers completed the CARS (test-retest reliability .85) and the Health Resources Inventory (HRI) that measured effective learning skills, adaptive assertiveness such as sharing opinions and defending positions, peer sociability, authority and rules, and frustration tolerance (test-retest reliability ranged from .72-.91). Child associates completed the Aides Status Evaluation Form (ASEF), which paralleled the CARS items with similar reliability. The supervising mental health professional completed the Professional Termination Report (PTR), which addressed disruptive behaviors, social skills with peers, social skills with adults, academic skills, overall academic achievement, emotional expression, and overall adjustment.

The program reduced acting-out, shyness, anxiety, and learning problems and promoted competencies including adaptive assertiveness, peer sociability, and frustration tolerance. Acting out behavior was the least affected by the program. Although this study confirmed the short-term effectiveness of *PMHP*, lack of a control group makes generalization from the conclusions difficult.

Another study compared 149 children in fourth and sixth grade from 19 classes in three racially mixed urban schools. One subset consisted of 61 students who had been in *PMHP* for at least three months, two or more years earlier and still attended the same school in which they received *PMHP* services. A comparison group consisted of 61 randomly selected children who had never been in the *PMHP* program matched for gender, school, grade, current classroom teacher, and number of years in the same school.

Because school records did not record *PMHP* participation, teachers were unaware of which youngsters had been in the program. A third subset consisted of two students identified by each of the 19 teachers as the least well-adjusted in their classrooms. Comparisons used three measures: teachers' ratings of students' problems and competencies, student's self-reports of perceived competence, and academic achievement. Repeated measures MANOVAs and appropriate Duncan multiple range tests were used for analysis. Comparing adjustment measures two to five years after participation with those taken at the time of initial referral and completion of the program evaluators, found that the *PMHP* sample maintained the gains established during the initial intervention period. Comparing across groups, they found that the never-seen students were the best adjusted, followed by the *PMHP* group, and then the least-adjusted group. There were no significant differences by gender or in academic achievement scores. This longitudinal study confirmed the durability of gains made by *PMHP* participants, but was limited by the retrospective matching, few outcome measures and small sample size.

Critique

More than 50 program evaluations have shaped and assessed the *Primary Mental Health Project*. These studies have shown that *PMHP* effectively strengthens young children's behavioral adjustment skills and academic achievement across socioeconomically diverse populations. Two to five years after participating in the program, students maintained gains. No prospective, longitudinal studies have compared those receiving and not receiving the program.

Evaluation Contact

A. Dirk Hightower, PhD
Director
Primary Mental Health Project
University of Rochester Center for Community Study
575 Mt. Hope Avenue
Rochester, NY 14620
PH: (716) 273-5957 / FAX: (716) 232-6350

Primary Prevention

Program Description

Houston Advocates for Mental Health in Children (HAMIC) is a nonprofit advocacy organization that has actively promoted mental health treatment services for children in Houston, Texas since 1974. Created in 1991, by HAMIC, *Primary Prevention: Promoting Mental Health in the Next Generation*'s purpose is to teach children about the relationship between parenting and children's mental health. The goal of the *Primary Prevention* program is to help K-12 students recognize how positive parenting practices influence a child's mental health. Such recognition could help break the cycle of dysfunctional parenting practices that cause low self-esteem, violence, substance abuse and depressive disorders in children.

Primary prevention consists of three curricula, one each for grades K-3, fourth to sixth grade, and seventh to 12th grade. Each curriculum has four components: building a foundation for mental health, self-esteem, raising children, and solving problems and getting help. Lessons address mental health, parenting styles, realities of raising children, parenting myths, positive discipline techniques and emotional abuse. Teaching methods include discussion, videos, role playing, written assignments and demonstrations.

A 1992 pilot in the Houston Independent School District used the curriculum for seventh- to 12th-grade students. The subsequently revised and expanded program has since received several community awards and a state-wide "Best of Texas" award in 1993.

Services Available

A seven-hour single day training is available for the program and includes a core curriculum and personalized instruction in program coordination and implementation. Cost of the training is $150 per person or $125 per person in groups of 10 or more, plus the trainers' expenses. Additional materials that are available include master handbooks (costs $60-$75 each), camera-ready graphics ($35), packaged pre/posttests ($50), videotapes ($50 each), transparencies ($15) and additional copies of curricula ($150).

Implications for Practice

An estimated 12 percent of U.S. children and adolescents suffer from mental disorders (American Medical Association, 1990). In addition, the rate of reported cases of child abuse and neglect rose from 22.6 cases per 1000 people in the United States in 1956 to 41.9 cases per 1000 people in 1990. These numbers reflect problems in parenting practices. *Healthy People 2000* objective 6.3 calls for reducing the prevalence of mental disorders among children and adolescents and objective 7.4 calls for reversing the rising incidence of maltreatment of children younger than 18. Programs such as *Primary Prevention* can foster healthy parenting skills and help reduce the incidence of emotional problems and abuse in children.

Audience		
	P	
	K^3	
	4^6	
	M	
	H	
	K^{12}	✓
	S	

Locale		
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Level		
	Cl	✓
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Components		
	C	✓
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	Sk	✓
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Emphasis		
	K	✓
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	B	✓

Janet Pozmantier
Program Director
6209 Skyline Dr.
Houston, Texas 77057-7007
PH: (713) 783-8470 / FAX: (713) 783-8858

Primary Prevention

✓	E	Design
	Q	
	I	Analysis
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	QI	Data
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Evidence of Program Effectiveness

One study of *Primary Prevention* looked at the K-3 curriculum; another assessed both the fourth- to sixth-grade and the seventh- to 12th-grade curricula. In both studies, program presenters (N=82) were school teachers, nurses and counselors who volunteered to learn about the program. Program students were from classes taught by the trained volunteers. In the K-3 study, 51 percent were African-American students and 37 percent Hispanic. In the fourth- to sixth-grade sample, students were 54 percent Hispanic and 41 percent African American. In the final sample, 52 percent were Hispanic students and 26 percent African American. Approximately 72 percent of the K-3 students and 76 percent of the fourth- to sixth-grade students were eligible for the state's free lunch program. Classes were randomly assigned to either a control or program condition (six each). Of the classes that received the program in each school, only one class participated in the study.

The research design for K-3 was a post only control group design with follow-up. For grades four to six and the grades seven to 12 curricula, the design was a pre/post control group with follow up. The questionnaires used were developed for the study. Reliability of the instruments, intended to measure knowledge and attitudes relevant to the program, Cronbach's alphas ranged from .54 to .66. Due to many factors, only four of the six program classrooms in the K-3 study and only 56 of 274 students in the seventh- to 12th-grade study completed follow-up measures. The grades seven to 12 study dropped analysis of follow-up data.

On the knowledge sections of the posttest the program group in all three studies scored significantly higher than control students. In each study, students in the higher grades scored higher than younger student. Students' follow-up scores on knowledge tests remained steady.

On the attitude sections, K-3 and fourth- to sixth-grade students reported a significantly less favorable attitude toward corporal punishment than the control group. Students in grades seven to 12 showed no changes in attitudes as a result of the program.

The K-3 study found a significant drop in the attitude measure at follow-up compared to the post test given 12-15 weeks earlier. The finding suggest that students retained parenting knowledge but not attitude changes. In the K-3 study, 69 of 82 program instructors completed a parenting attitude questionnaire before and after training. Trainees endorsed more non-abusive attitudes on the post test than on the pre test. At both pre- and post-training, Caucasian instructors were less supportive of corporal punishment than African Americans and were less likely to expect children to meet parents' needs. In the grades four to six study, students in the program classes increased their knowledge and attitude scores more when taught by their classroom teachers than when taught by trained school nurses, counselors or other teachers. No such differences existed among instructors in the seventh- to 12th-grade study.

Critique

Programs such as *Primary Prevention* show promise for decreasing the incidence of mental health problems. Unfortunately, the program's measures of knowledge and attitudes did not assess *Primary Prevention*'s potential to decrease the incidence of mental health problems among students or their eventual children. Attrition presented a problem and researchers reported no data showing comparability of control and program students or of those assessed and those lost to attrition. Samples consisted of classes taught by adults who volunteered for training which might cause a selection bias. The program's premise is interesting enough that further evaluation is probably warranted. The number of concepts assessed was small (for example, only one attitude about corporal punishment was measured).

Evaluation Contact

Joseph M. Peraino, PhD, and Associates
3555 Timmons Lane, Suite 1280
Houston, TX 77027
PH: (713) 840-1577

Project for Attention Related Disorders

Program Description

The *Project for Attention-Related Disorders* (*PARD*) was developed in 1989 by the San Diego, Calif. City School District to improve the identification, referral and management of children with attention deficit and hyperactivity disorders (ADHD). *PARD* is a school-based system that coordinates the medical, psychosocial, behavioral, and educational programs for children with ADHD and their families. Support for the project comes in part from the Maternal and Child Health Bureau (Title V Social Security Act) of Health Resources and Services Administration, U.S. Dept. of Health and Human Services and the California Medicaid Program (MediCal).

One goal of the project is to develop a reliable, school-based system to identify children who have problems concentrating. Once a classroom teacher identifies such a child, a Child Study Team compiles a profile of the child. The school nurse completes each child's history and physical. Parents complete a questionnaire regarding the health and social history of the child. The evaluation includes a Conners checklist that rates various behaviors such as "restless in a 'squirmy' sense" on a scale of zero to three with zero being "not at all" and three being "very much." A summed score of 15 or greater suggests that the child might have ADHD. The *PARD* referral packet is then sent to a local physician who volunteers to review the information and prescribes the appropriate treatment which might include medication or counseling. As of 1994 over 1,200 children had been referred to the project with over 900 (75 percent) receiving some form of treatment.

A second goal is to increase the knowledge, skills and confidence of teachers, nurses, community physicians and parents working with ADHD students. To meet this goal, *PARD* staff provide in-service training and technical assistance. A teacher intervention manual can help teachers modify the curriculum and make program adjustments.

Services Available

Materials available include an intervention handbook for use by school personnel in the evaluation of the children, a project report and technical assistance.

Implications for Practice

Although an estimated 12 percent of U.S. children and adolescents suffer from mental disorders severe enough to warrant treatment, less than one out of eight receives treatment. Estimates of ADHD prevalence vary dramatically. Characteristics of the disorder include inattention, poor concentration, impulsiveness and hyperactivity – all of which can negatively impact academic performance as well as psychosocial development. ADHD children are at increased risk of child abuse due to parents' frustration with unruly behavior. School-based programs that offer early intervention can provide an important tool for reducing negative effects. Such programs also help meet *Healthy People 2000* objective 6.14: "increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral and follow up, in their clinical practice."

Audience		
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	K^{12}	✓
	S	✓

Locale		
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Level		
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Components		
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Emphasis		
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Susie Horn, RN
San Diego Unified School District
San Diego City Schools
Health Services Dept.
2716 Marcy Ave.
San Diego, CA 92113-2395
PH: (619) 525-7370

Project for Attention Related Disorders

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Evidence of Program Effectiveness

Evaluations of this project used both process and outcome methods. Between March 1990 and June 1992, teachers identified 250 low-income children in the San Diego Unified School district as having attention-related problems and referred them to the *PARD* staff. Of these, 110 (44 percent) completed their evaluation. The ethnic breakdown of the students included 34 Whites, 32 African-Americans, 34 Hispanics, two Asians and eight students unspecified. The majority (86 percent) were male. Of the 96 (87 percent) children with an initial Conners score greater than 15.45, 52 percent were placed on medication as were four children with lower Conners scores. Sixty-seven percent of the children received one or more special behavioral or educational interventions: 36 percent received counseling, 21 percent joined the resource specialist program, 18 percent entered a special day class, 13 percent were designated learning handicapped, 8 percent were designated severely emotionally disturbed and 5 percent received speech therapy. Thirty-three percent received no special behavioral or educational interventions.

At the end of each school year, the teacher reevaluated each child using the Conners checklist. The combined comments from the teacher and school nurse measured success of the project. Forty-eight (44 percent) children had insufficient data to complete the outcome evaluation. Of the remaining 62 children 11 improved greatly (18 percent), 28 improved moderately (45 percent), seven improved slightly (11 percent), 10 were unchanged (16 percent), and six were worse than before enrollment (10 percent).

Critique

The development of a systematic school-based approach to the evaluation and management of children with learning problems is an important goal. However, *PARD*'s evaluation yields little insight. Effectiveness of the program is difficult to determine for a number of reasons, but primarily because of incomplete or missing data and high attrition rates. For example, 32 youth had missing or incomplete initial history forms, 21 children did not have the initial parent Conners score, 10 children did not have initial Conners scores from a teacher, 47 lacked the second teachers' Conners score, and 48 children did not have evaluation comments from the teacher or nurse.

In addition, parents did not follow-up with a physician, some parents refused the *PARD* evaluation, other parents refused medications, parents denied a problem existed, and parents took the children off medication without the advice of their physician. The study lacked a comparison group or instruments to measure effectiveness. The follow-up period was short and the small sample size might have excluded children not covered by insurance. In addition, the evaluation did not address whether the behavioral ratings were clinically and educationally significant or whether learning and academic achievement improved. The study made no mention of the negative effects of incorrect diagnosis, a common concern in the mental health community.

Evaluation Contact

Laura Aird
Community Health Services
American Academy of Pediatrics
141 Northwest Point Blvd.
P.O. Box 927
Elk Grove Village, IL 60009-0927
PH: (708) 228-5005 / FAX: (708) 228-5097

Project Northland

Program Description

Project Northland is a community-based, school-linked, alcohol-use prevention program for students in grades 6-8. Project Northland began in 1991 as a research trial sponsored by the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health. The program uses classroom instruction, peer leaders, parent involvement and parent education, as well as community-wide activities.

In the sixth grade, students learn to communicate with their parents about alcohol using the *Slick Tracy Home Team Program*. The curriculum uses activity books with the characters "Slick Tracy" and "Breathtest Mahoney" to promote parent/child discussions of alcohol, peer influence, media influence and home rules during four consecutive weeks. *Northland Notes for Parents,* included in each *Slick Tracy* activity book, provides background information on adolescent alcohol use. Ideally, community task forces develop collaborative efforts across the community: government, law enforcement, school representatives, business, health professionals, youth workers, parents, concerned citizens, clergy and youth.

In the seventh grade, youth learn to deal with peer influences and normative expectations about alcohol. The *Amazing Alternatives! Program* draws from models used by the World Health Organization and the Massachusetts Saving Lives Program. It includes a kickoff evening with parents, an eight-week peer- and teacher-led classroom curriculum, a peer participation program to create alternative alcohol-free activities (TEENS), four booklets for parents and three new issues of *Northland Notes for Parents*. Students select peer leaders that they "like and respect" in an open election. A one-day leadership training includes planning a budget for an activity and publicizing an activity. Adult volunteers facilitate the TEENS groups. The community task force activities focus on passing of alcohol-related ordinances and providing discounts at local businesses for students who pledge to be alcohol and drug free.

The eighth-grade program *PowerLines* is an eight-session, peer-led curriculum, which introduces students to the concept of "power groups." Power groups are individuals and organizations within a community that influence adolescent alcohol use and availability. The curriculum teaches students community action and citizen participation skills. Students interview various power groups within the community and conduct a "town meeting" in which small groups of students represent the interests of those they have interviewed and make recommendations for community actions to prevent alcohol use among youth. The curriculum also includes a theater production called "It's My Party," three new issues of *Northland Notes for Parents* and the continuation of the TEENS groups and task force activities.

Services Available

The sixth-grade teacher's manual costs $50; each student activity book costs $6. The seventh-grade teacher's manual costs $125. The home program includes four activity booklets and costs $30. The *Alternatives!* program guide is $10. The eighth-grade teacher's manual costs $100 which includes audio tapes, transparencies and masters of all student materials.

Implications for Practice

The *1995 Youth Risk Behavior Survey* found that 80 percent of high school students had tried alcohol, slightly over half were current users and 32 percent admitted to episodic heavy drinking. Alcohol is implicated in the three leading causes of death among youth: motor vehicle crashes, homicide and suicide, as well as other high-risk behaviors, such as early sexual initiation and delinquency. Objectives 4.5 through 4.10 of *Healthy People 2000* address reducing alcohol use by adolescents. *Project Northland* builds on alcohol and drug prevention research of the past two decades. It addresses both individual behavioral change and environmental change, using multiple strategies including peers and parents during the critical years of middle school.

Audience		
	P	
	K[3]	
	4[6]	
	M	✓
	H	
	K[12]	
	S	

Locale		
	R	✓
	U	
	S	
	M	

Level		
	Cl	✓
	B	
	D	
	Co	✓

Components		
	C	✓
	St	✓
	Pe	✓
	Pa	✓
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	
	A	✓
	N	✓
	B	✓

Sara Veblen-Mortenson
Division of Epidemiology
School of Public Health
University of Minnesota
1300 S. Second Street, Suite 300
Minneapolis, MN 55454
PH: (612) 624-9378 / FAX: (612) 624-0315

Project Northland

✓	E	Design
	Q	

	I	Analysis
	G	
	B	
✓	D	
	C	
	M	

	QI	Data
✓	Qn	
	B	

	F	Type
✓	S	
✓	O	
	P	

Evidence of Program Effectiveness

The *Project Northland* evaluation involved approximately 2,400 students in the Class of 1998 from 24 school districts in northeastern Minnesota during their sixth-, seventh- and eighth-grade years (1991-1994). Students were primarily white (94 percent) and from rural, middle to lower-middle class communities. The school districts were randomly assigned to be program districts or comparison districts. Annual surveys of students and parents asked about alcohol use, tobacco use and various psychosocial factors. The student questionnaire contained items relating to the curricula; tendency to use alcohol (which combined items about intentions to use alcohol and actual alcohol use); peer influences; self-efficacy (defined as confidence in being able to refuse offers of alcohol); communication with parents; normative expectations about alcohol use; perceptions of ease of access to alcohol; attendance at activities with or without alcohol; and demographic factors. The measures of psychosocial factors (peer influence, self-efficacy and perceptions of access to alcohol) had satisfactory psychometric properties.

The unit of analysis was the school district. Mixed model regression methods (ANCOVA) tested for differences between groups. Subsequent analyses adjusted for differences in baseline alcohol use and race. Of the 2,351 students present at baseline, 93 percent, 88 percent and 81 percent were surveyed at the end of the sixth, seventh and eighth grade, respectively. Of the 19 percent lost to follow-up, no significant differences existed in baseline alcohol use between the program and comparison group.

At the end of three years of program exposure, students in the intervention districts (N=1901) were significantly less likely to use both alcohol and cigarettes than students in the comparison districts. Students in the intervention group who were "never drinkers" at the beginning of sixth grade, but who eventually did use, drank significantly less than students in the comparison districts. They also smoked 37 percent fewer cigarettes and used 50 percent less marijuana by the end of the eighth grade. Monthly drinking was 20 percent lower, and weekly drinking was 30 percent lower among students in the program districts compared with comparison districts.

In addition, the program changed normative perceptions about how many young people drink, parent-child communication about the consequences of alcohol use and the importance of reasons for not using alcohol. Students in the program districts had significantly lower scores on the peer influence scale by the end of eighth grade, although there were no significant differences in the Self-Efficacy or Perceived Access Scales. Other psychosocial measures showed that by the end of the eighth grade students in the program districts were significantly more likely to perceive that drinking was not accepted and significantly less likely to report that people their age drink alcohol when on a date. At the end of the eighth grade, students in the program districts were significantly more likely than those in the control districts to view nine of 10 suggested reasons as important for not using alcohol.

Critique

Project Northland demonstrated promising changes in self-reported adolescent behaviors. The project was more successful with students who had not used alcohol at the beginning of sixth grade than among those who had already initiated use. Future evaluation studies could be strengthened by matching communities based on race and alcohol use at baseline before randomizing to treatment or comparison groups. The study involved primarily white students from rural, middle- to low-income families in Minnesota. Generalizations can not be made to other groups or settings.

Evaluation Contact

Kelli Kormo, MPH, PhD
Division of Epidemiology
School of Public Health
University of Minnesota
1330 S. Second St., Suite 300
Minneapolis, MN 55454
PH: (612) 625-7333 / FAX: (612) 624-0315

Project Taking Charge

Program Description

Project Taking Charge is a combined sexuality and vocational education program that promotes abstinence from sexual activity. The American Association of Family and Consumer Sciences (formerly the American Home Economics Association) began the program in 1989 with funding from the U.S. Office of Populations Affairs' Office of Adolescent Pregnancy Prevention. Field-testing of the original program was with middle school students.

A 1993 revision, which includes a Spanish version named El Futuro Es Mio, targets low-income seventh-grade students in home economic classes and their parents.

Lessons prepare youth to make choices about sexual activity and other issues they will face as they mature. Topics such as vocational exploration (which includes a job shadowing exercise) and decision making help participants "take charge" of their psychosexual development and plan for their future and the world of work. The program also helps parents "take charge" of communicating sexual information and standards to their adolescent children, as well as of helping their children prepare for achieving their occupational goals.

The curriculum consists of five instructional units of 55-60 lessons, each lasting one-class period. The curriculum takes six to nine weeks to implement. Each lesson includes objectives, materials needed, bulletin board ideas and suggested daily activities. Materials include student worksheets and homework assignments, teacher resources and transparency masters. The program incorporates three parent and youth sessions for use in a community setting during evening hours. The parent involvement portion includes communication exercises, value exploration and factual material relating to adolescent sexuality.

Services Available

The 500-page curriculum costs $75 for American Association of Family and Consumer Sciences members and $100 for nonmembers. Training manuals cost $35 for members and $45 for nonmembers.

Implications for Practice

Although recent statistics indicate birth rates among teenagers are declining, teen pregnancy remains a significant problem in this country. The United States continues to have the highest adolescent pregnancy rate in the industrialized world — over one million each year. Rates of pregnancy and sexually transmitted disease among younger teens are increasing . A key national strategy to combat this problem is to support and encourage young adolescents to remain abstinent. *Project Taking Charge* is a comprehensive program that encourages teens to postpone sexual activity and helps youth and their parents understand the connections between education, occupational goals, sexual activity and early childbearing.

Audience	P	
	K^3	
	4^6	
	M	✓
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	K^{12}	
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Locale	R	
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	M	✓
Level	Cl	✓
	B	
	D	
	Co	
Components	C	✓
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	Pe	
	Pa	✓
	M	
	P	
	Sk	
	Se	
Emphasis	K	✓
	A	✓
	N	
	B	

Rosemary Bolig
Project Manager/Consultant
American Association of Family and Consumer Sciences
1555 King Street
Alexandria, VA 22314
PH: (800) 424-8080, (703) 706-4600 / FAX: (703) 706-4663

Project Taking Charge

	E	Design
✓	Q	

✓	I	Analysis
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	QI	Data
✓	Qn	
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	F	Type
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✓	O	
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Evidence of Program Effectiveness

A six-month follow-up evaluation of the original version of the project was conducted in 1989. An evaluation of a revised program occurred in 1994 in three sites: Oklahoma City, Dallas and Miami. Both studies involved three program and three control classrooms in different cities. In both studies, home economics teachers randomly selected a class as a treatment group and another as a control group. Pretest differences between groups were minimal in both studies. Any significant pretest differences became covariates for ANCOVA analyses of the posttest data.

The research design of the first study used a pre/posttest and a six-month follow-up questionnaire. The second study did not include the follow-up measure. The variables of interest included the adolescent's self-esteem; knowledge about sexual anatomy, pregnancy and sexually transmitted diseases; attitudes and intentions relating to sexual behavior; sexual values; communication with parents about sexual and vocational issues (frequency and comfort); and educational aspirations. A panel of five social scientists reviewed the instruments for face validity. Reliability of the instrument varied by subtest, but most were within acceptable limits. Reliability was poor for measures of clarity of sexual values and knowledge of the consequences of adolescent pregnancy.

In both studies, the pre/posttest analysis revealed significant differences in knowledge gain between students in the program and control classes. There were no significant changes in self-esteem scores and no improvement in students' understanding of the complications resulting to their educational and employment future caused by teenage pregnancy. There were also no differences between students receiving the curriculum and the controls in acceptability of adolescent sexual intercourse or behavioral intentions. The program did not improve communication between parents and their adolescent children.

The six-month follow-up indicated that most of the knowledge gain was retained. Those in the program tended to delay initiation of sexual activity more than those in the control group at the follow-up measure, but the difference was not statistically significant.

Critique

Project Taking Charge might fit well with community norms in areas that struggle with incorporating birth control information in pregnancy prevention programs. The program's abstinence focus limits controversy over program content. Both evaluation studies relied on a small number of self-reports. The only significant differences between program and control classes were modest changes in knowledge scores. Few parents participated in the parent-child communication component and fewer still completed pre/posttests.

Evaluation Contact

Stephen R. Jorgensen
Dept. of Human Development and Family Studies
Texas Tech University
Lubbock, TX 79409

Project TNT

Program Description

Project TNT is a middle school tobacco use prevention curriculum. The curriculum addresses the three most common factors found to influence tobacco use among adolescents: 1) seeking peer approval by using tobacco; 2) seeking a desired social image associated with tobacco use; and 3) lack of knowledge about physical consequences resulting from tobacco use. The curriculum addresses both cigarettes and smokeless tobacco.

The curriculum consists of 10 lessons presented over a two-week period in the seventh grade and two booster lessons for use in eighth grade. It includes active listening, consequences of tobacco use, self-esteem building, how to resist peer pressure and still be liked, effective communication skills, refusal skills, critical thinking regarding advertising messages, social activism against tobacco use and public commitment not to use tobacco. *Project TNT* uses a variety of teaching methods including group discussion, games, role plays, videos, student worksheets, questioning, analyzing media influences, and production of a class videotape using a news program format to present previously learned information.

Project TNT grew out of a five-year research project that tested the effectiveness of various social influence strategies to prevent tobacco use. The National Cancer Institute and the National Institute on Drug Abuse funded the project. The Centers for Disease Control and Prevention's Division of Adolescent and School Health (DASH) has identified Project TNT as a curriculum with credible evidence of effectiveness in reducing the initiation of cigarettes and smokeless tobacco, designating it as a *Program that Works* as part of CDC's *Research to Classroom* project.

Two days of teacher training is recommended.

Services Available

The curriculum consists of a teacher's manual, student workbook, two videos and an optional kit of posters and instructional materials. Contact ETR Associates for current prices.

Implications for Practice

Tobacco use is responsible for more than one of every five deaths in the United States and is the most important single preventable cause of death and disease. *Healthy People 2000*'s objective 3.5 calls for reducing the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20. The overwhelming evidence of the addictive nature of nicotine necessitates a continued commitment to preventing tobacco use among young people through enforcement of youth access laws, effective prevention education programs, such as *Project TNT,* in schools and communities and limiting the effect of tobacco advertising and promotion on youth.

Audience		
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Locale		
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Level		
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Components		
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	Sk	✓
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Emphasis		
	K	
	A	
	N	✓
	B	✓

for materials:
ETR Associates
4 Carbonero Way
Scotts Valley, CA 95066
PH: (408) 438-4060.

for training:
Sandi Craig
Institute for Health Promotion and Disease Prevention Research
University of Southern California
1000 S. Fremont Ave. Suite 641
Alhambra, CA 91803-1358
PH: (213) 342-2589

Project TNT

✓	E	Design
	Q	
	I	Analysis
	G	
✓	B	
	D	
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	M	
	QI	Data
✓	Qn	
	B	
	F	Type
✓	S	
✓	O	
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Evidence of Program Effectiveness

Forty-eight junior high schools in southern California were randomly assigned to one of the four program conditions or to a "usual-practice" control condition. In the program schools, trained project health educators delivered the curriculum to seventh-grade students. In control schools, school personnel delivered their usual health education. Of the 6,716 seventh-grade students who answered pre and post self-report questionnaires, 50 percent were male, 60 percent were White, 27 percent were Hispanic, 7 percent were Black and 6 percent were Asian or "other." Two years later, 7,219 ninth-grade student answered the same questionnaire. Before each survey administration a saliva or breath sample was collected from a sample of students to increase the accuracy of self-reported tobacco use even though the samples were not analyzed.

Four behavioral measures included two items assessing the rates of initial trial of cigarettes and smokeless tobacco and two that measured rates of weekly use. T-tests compared the ninth grade prevalence of these measures between male-female aggregates and urban rural regions. ANCOVA tested a five-group model with school as the unit of analysis. Covariates included a measure of school "turnover" (defined as the proportion of new students attending the school at the two-year follow up), region and gender.

At the end of the two year follow-up, compared to those in comparison schools, students in Project TNT schools reduced initiation of cigarette use by about 26 percent and smokeless tobacco use by about 30 percent. *Project TNT* reduced weekly, or regular use of cigarettes by about 50 percent and smokeless tobacco by 100 percent. The curriculum was effective with all racial groups. Among those students who tried cigarettes by the ninth grade, the change in prevalence between program and control schools was 17 percent.

The findings indicated that males and females experimented equally, though more rural than urban students had tried cigarettes by the ninth grade – 60 percent vs. 52 percent. More male than female students tried smokeless tobacco (20 percent vs. 4 percent), and more individuals in rural than urban regions (12 percent vs. 9 percent). Change in trial of smokeless tobacco use was small (4 percent overall), which did not vary by gender or region. Weekly smoking prevalence was 14 percent at ninth grade, an increase of 8 percent, which did not vary by gender or region. Weekly smokeless tobacco use was 4 percent in both regions but virtually all weekly use was reported by male students (7 percent vs. less than 1 percent).

Critique

This well-designed and rigorous study demonstrated that *Project TNT* reduced initiation of tobacco use as well as quantities used. Health educators hired and trained by *Project TNT* delivered the curriculum. Fidelity to the curriculum was not an issue. In a "real world" implementation, results might be less favorable. Previous research has shown that school-based interventions implemented in junior high school have little long-term effect unless reinforced with additional programming in high school. High school booster materials should apply to social situations of high school students (e.g. jobs, unsupervised recreational time, dating).

Evaluation Contact

Steve Sussman, Ph.D.
Institute for Health Promotion
and Disease Prevention Research
University of Southern California
1000 S. Fremont Ave., Suite 641
Alhambra, CA 91803-1358
PH: (213) 342-2589

Rapping with Vince and Larry

Program Description

Rapping with Vince and Larry was developed by the Michigan Department of Public Health in cooperation with the Michigan Department of Highway Planning, the Michigan Academy of Family Physicians and Ottawa County Human Services to increase safety belt use and awareness among children in third to fifth grade. The 45-minute program uses an eight-minute educational videotape that stresses the importance of safety belt use, demonstrates the proper way to wear a safety belt and reinforces the notion that it is acceptable to ask others to buckle up.

The Michigan State University Theater Department developed a brief skit that expands on the video information using music and a rap song and featuring the National Highway Traffic Safety Administration's Vince and Larry crash dummies. These characters, made popular through national public service announcements, were chosen because they are comical, nonthreatening role models for safety belt use. After seeing the video and skit, students are asked to sign a pledge to wear safety belts. They have a picture taken with the crash dummies, which is placed in an autographed picture frame. The children are encouraged to place this visible reminder to buckle up in the family car as a means to further reinforce this behavior. As students wait to have their picture taken, they work on an activity sheet with a maze and word search puzzle about seatbelt use.

Services Available

The Game of Your Life video, Vince and Larry costumes (available for loan), Polaroid cameras (available for loan), Vince and Larry Picture frames, rap music and skit are available.

Implications for Practice

In the United States, motor vehicle crashes are the most common cause of death for persons aged 1-14, outranking all other injuries and diseases as the leading cause of death. The costs resulting from these crashes are high, not only in terms of medical care costs, but because so many of the victims are young – thousands of years of productive life are lost. The consistent and proper use of safety belts can prevent many of these deaths. The *Healthy People 2000* objective 9.3A is to reduce deaths cause by motor vehicle crashes to no more than 5.5 per 100 million vehicle miles traveled. *Rapping with Vince and Larry* is a developmentally-appropriate strategy that encourages children to establish the lifesaving habit of using safety belts.

Audience		
	P	
	K^3	✓
	4^6	
	M	
	H	
	K^{12}	
	S	

Locale		
	R	
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	S	
	M	✓

Level		
	Cl	✓
	B	
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Components		
	C	
	St	
	Pe	
	Pa	
	M	✓
	P	
	Sk	
	Se	

Emphasis		
	K	✓
	A	✓
	N	
	B	✓

Heather Festerling, MA
Michigan Department of Community Health
P.O. Box 30195
Lansing, MI 48909
PH: (517) 335-9510 / FAX: (517) 335-8397

Rapping with Vince and Larry

	E	Design
✓	Q	

✓	I	Analysis
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	B	
	D	
	C	
	M	

	QI	Data
✓	Qn	
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	F	Type
	S	
✓	O	
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Evidence of Program Effectiveness

The program evaluation was conducted in 1990 using pre/posttest surveys of safety belt use, knowledge and attitudes. Children from 12 elementary schools completed questionnaires three weeks before the program took place (1,087 cases and 1,017 controls) and again two weeks after the intervention (1,049 controls and 1,014 controls). Comparison students were from the same schools and grades as the program groups but did not receive the program. No information was provided on the selection of students for program or control. Students ranged in age 8-14, although 99 percent of the children were age 12 or younger. All case schools completed a principal and teacher questionnaire regarding the appropriateness of the intervention components (video, tape skit and pictures) and their general reactions to the project.

Researchers looked at frequency of seatbelt use for front and back seats and for short and long trips. They reported no significant difference between program and control groups for the preprogram survey. All students had a greater tendency to wear their seatbelt when riding in the front seat and during longer trips. The post intervention survey revealed significant increases ($p<.01$) of self-reported seatbelt use for the front seat (+8.1 percent), back seat (+6.7 percent) and short trip use (+6.9 percent) by the program group.

Changes in attitudes and knowledge about wearing seatbelts were examined with questions such as, "Kids should always wear a seatbelt when riding in the front seat," and "It is OK to ask others to wear a seatbelt." Although the preprogram survey indicated no significant difference between program and comparison groups, the posttest showed significant increases in the program group's belief that they should always wear a safety belt when riding in the back seat (+8.7 percent), that it was appropriate to ask others to buckle up (+5.7 percent) and that seatbelts protect a person by keeping them inside the car during a crash (+6.4 percent).

The survey of principals and teachers found that they felt the program was most appropriate for younger students, fifth-grade students were less receptive and third-grade students were most receptive. Additional teacher comments included concerns that the program is too entertaining and therefore students do not take seriously the importance of seatbelt use. The photographs seemed to be a keepsake rather than a safety belt reminder, since only 18.6 percent of students kept the photos in the family car, as advised. Teachers noted the importance of parental involvement in the program.

There was no increase in self reported knowledge about proper seatbelt use. However, over 98 percent of both program and comparison group recognized correct safety belt use from a choice of four illustrations on the pre-course survey.

Other findings included the fact that females were more likely than males to use safety belts in all categories. For short trips urban students were more likely than rural students to wear seatbelts. Rural students were significantly more likely to believe children should always wear a safety belt in the back seat.

Critique

The *Rapping with Vince and Larry* program utilizes community resources and a multimedia approach to send a safety message that is not always readily accepted. The program appears to capture the attention of younger children, as well as change reported seatbelt usage for a short while. The lasting impact of a onetime presentation is unknown, since posttests were two weeks after the program. Children need the opportunity to practice buckling and the inclusion of parents is critical to establishing and reinforcing this important message.

Evaluation Contact

Health Surveillance Section
Center for Health Promotion
Michigan Department of Public Health
P.O. Box 30195
Lansing, Michigan 48906
PH: (517) 335-8657

Reach Out to Schools (Open Circle)

Program Description

The *Reach Out to Schools Social Competency Program* (*SCP*), commonly referred to as *Open Circle*, is a multi-year program for students in grades K-6, their teachers, principals and parents. *SCP* began in 1987 as a pilot program funded by the Stone Center for Developmental Services and Studies at Wellesley College. It is based on a theory that connects social and academic development. A fundamental assumption is that one role of schools is to help socialize children by teaching them appropriate interactions for developing into healthy, productive adults.

The program seeks to prevent violence and foster social and academic development by emphasizing cooperation, inclusion, boundary definition, clarity of behavioral expectations and positive and consistent reinforcement. It uses the *Quality of School Life* curriculum developed by Ruth Schelkun. The curriculum has three themes: creating a cooperative classroom, building self-esteem and positive feelings, and solving interpersonal problems. For example, children learn that it is appropriate to report to an adult when another's behavior is "dangerous or destructive - the Double D guideline". Otherwise they are taught strategies that enable them to handle situations themselves. During 15-minute, twice-a-week "open circle" meetings, students use role-plays, discussions, practice exercises, hypothetical problem solving, team building exercises and homework to learn social skills and discuss issues of personal and group importance. The 40 lessons of the curriculum require a sustained, yearlong commitment. Lessons have been developed for both the primary and intermediate grade levels and for both experienced students, who have had the program, and new students. The curriculum teaches a common language that includes both verbal and nonverbal signals for communication and a vocabulary for labeling feelings. It also includes a series of workshops to familiarize parents with the program.

Services Available

SCP costs $650 per teacher and includes four days of training, consultation and curriculum materials. Schools are encouraged to send a leadership team of three to four teachers for the four-day training. A one-day principal training is included in the teacher fee. On-site consultation is available to schools in eastern Massachusetts.

Schools can receive other services for additional fees including parent, teacher and principal workshops. Wellesley College offers Professional Development Points and three hours of graduate credit at an extra cost.

Implications for Practice

According to the *Healthy People 2000 Midcourse Review and 1995 Revisions,* few issues pose a greater challenge to public health and American society than violence. The United States ranks first among industrialized nations in violent death rates and youth are increasingly involved as both perpetrators and victims of violence. According to the *1995 Youth Risk Behavior Survey*, 38.7 percent of high school students had been in a physical fight during the preceding year and 20 percent of students had carried a weapon within 30 days prior to being surveyed. Based on the belief that childhood problems are often the result of deficient social skills which are associated with adjustment problems in adolescence and adulthood the National Institute of Mental Health, in 1986, recommended that all school curricula include social competency building instruction as a way to prevent social and behavioral problems in children. The *SCP* addresses this issue and thus might help decrease social and behavioral problems at the primary school level and perhaps reduce student adjustment problems, including violence, at the secondary school level.

Audience		
	P	
	K[3]	✓
	4[6]	✓
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	K[12]	
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Locale		
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	M	✓

Level		
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Components		
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	Pe	✓
	Pa	
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	Sk	✓
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Emphasis		
	K	
	A	✓
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	B	✓

Pam Seigle
Program Director
Reach Out to Schools Social Competency Program
The Stone Center for Developmental Services and Studies
Wellesley College
Wellesley, MA 02181
PH: (617) 283-2847 / FAX: (617) 283-3646

Reach Out to Schools (Open Circle)

	E	Design
✓	Q	
	I	Analysis
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	D	
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	M	
✓	QI	Data
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	F	Type
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Evidence of Program Effectiveness

SCP was evaluated in several studies between 1990 and 1995 using both qualitative and quantitative methods. The latest evaluation, in 1994-95, used a qualitative design to examine the impact of the program on teaching practices and interactions among and between students and teachers. At the time, 481 grade K-6 classrooms in approximately 70 schools used the program. The evaluation involved 179 teachers, 19 of whom were teacher/leaders and 42 principals, 13 of whom had two to five years of previous experience with the program. Data was collected at the beginning of the school year, midyear and at the end of the year using narrative writing and numerical responses to a set of questions. The evaluator and teacher/leaders conducted classroom observations. Teachers new to the program documented how becoming trained in the program affected their teaching and their relations to students. Experienced teachers described the impact of the curriculum on their students and classroom.

In response to the question: "Did you observe significant gains in the social competency skills of your students in their interactions as a result of *Open Circle* this year?," 67 percent of the teachers reported that students gained skills in relating to other group members, with each other individually, and in solving problems. In response to "In what ways, if any, is your classroom different from previous years as a result of the program?," 50 percent of the teachers felt that the children criticized, teased and tattled less. Tattling indicated that a child wanted a teacher to fix a problem brought on by another child. If children tattle less, they are presumed to be more empowered to solve some of their own problems with each other. Sixty-four percent of teachers believed students were more responsible and more in control of their behavior. For example, teachers noted an increased use of words to solve problems rather than use of dangerous and destructive behavior. In response to a question about difficulties, 17 percent of teachers commented about the length of time needed to cover all the topics and 25 percent described resistant behavior among children. Many of the examples cited as "resistant," the evaluators interpreted as unrealistic expectations for the program, for student behavior and for teachers of themselves. Other concerns cited by 11 percent of the respondents revealed the presence of problems that required clinical treatment and intervention beyond the scope of the program. Eight percent of the teachers noted improvements in the individual behavior of shy students.

In regard to the impact of the program on their own behavior, many teachers felt that the program provided a means of personalizing their relationship with students without compromising their professionalism - 38 percent cited improved listening abilities and conflict resolution skills and 33 percent noted improved relationships with students. Thirty-three percent of teachers said the program supports and compliments their style of teaching while another 36 percent changed their teaching practices as a result of the program. The evaluator concluded that *SCP* appears to be successful not only for teachers who have a natural affinity for the program but for other teachers as well. In addition, an unintended outcome appears to be greater self-reflection among teachers regarding their work. Twenty-five percent of principals reported that the teachers were calmer and worked better as a team, providing increased social support for each other's teaching. Principals also reported that the program provided a consistent and unified approach using a common language to develop social competency in students. Many noted that the benefits generalized beyond the classroom, citing recess play as being more civilized with fewer disciplinary problems.

Critique

The findings of the *SCP* evaluation suggest that it can promote social competencies and foster cooperative classroom and school environments. However, the study lacks comparison data with other schools or with quantitative baseline data regarding the number of disciplinary events before and after the program within the classroom and school. The data does not include specific health behavior measures or indicators. The study provides no evidence of reliability or validity of measures used.

Evaluation Contact

Barbara Black
Evaluation Consultant
177 Lakeview Avenue
Cambridge, MA 02138

Reconnecting Youth

Program Description

Reconnecting Youth (*RY*) is a peer group approach to building life skills developed by Leona Eggert, Liela Nicholas and Linda Owen at the University of Washington's School of Nursing. The program's theoretical frameworks are social network support theory, social learning and control theories. *RY* was field tested for five years with funding from the National Institute on Drug Abuse and the National Institute of Mental Health. A major assumption of the program is that school drop out and drug abuse are co-occurring problems with common precursors. The program targets youth who "skip" school to get "high" and for whom drug use becomes a critical dimension of their culture and interactions with peers. The program's goals are to teach these truant and underachieving youth to manage their anger and decrease drug use, improve school attendance and achievement and reduce depression and suicide risk.

Using a risk/protective factors model, the program identifies protective factors in an individual's personal and social network (peers, family and school). Program components include building positive teacher-to-student and peer group relationships through small group interaction and skills training. For example, participants learn how to identify their own anger "triggers", use control strategies when they first feel anger, and express anger constructively. The curriculum contains 80 lessons that teachers or youth leaders can use sequentially, selectively or infused into other curricula. Three days of staff development are recommended.

As of 1996, *RY* was in 1,400 sites throughout the United States. The National Institute on Drug Abuse has recognized *RY* as one of the nation's three most effective substance abuse prevention programs. It is appropriate for seventh to 12th grade.

Services Available

The leader's guide/curriculum costs $125 for members of the National Education Service and $139 for nonmembers. A training guide costs $21 for members and $23 for nonmembers.

Implications for Practice

Although drug use among adolescents has shown declines in recent years, this drop appears to be mostly among casual or experimental users. Rates for frequent users have not dropped significantly and drug use by adolescents remains a major health and social problem in the United States. A number of objectives in *Healthy People 2000* call for reductions in the use of alcohol and other substances by youth. Objective 4.13 seeks to provide drug education programs for all children and youth, preferably as part of a comprehensive school health program. Objective 8.2 calls for increasing the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health.

Audience		
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Locale		
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	A	✓
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	B	✓

Peter R. Brooks
Communications Director
The National Education Service
1252 Loesch Road
Blooming, IN 47404
PH: (812) 336-7700 / FAX: (812) 336-7790

Reconnecting Youth

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Evidence of Program Effectiveness

An initial pilot study demonstrated significant differences between experimental and comparison groups (N=73 in each group). Program participants decreased their truancy and drug involvement, and increased their school achievement compared to control students.

A 1994 study involved high risk youth at four high schools in the Pacific North West. For the purpose of the study, the definition of high risk students was that they had below the expected number of credits for current grade level, were in the top 25th percentile for days absent per semester, had a grade-point average (GPA) of less than 2.3, had a pattern of declining grades or a precipitous drop in GPA greater than .7, prior school dropout status or referral from school personnel for being in serious jeopardy of school dropout, failure, or suspension. A total of 542 such students were randomly selected to participate either as a control student (complete a survey) (N=232) or as a program participant (enroll in semester-long course) (N=310). Refusals from students selected for the program condition were generally for one of three reasons -- class schedule conflicts, lack of interest, or a perceived lack of need for the prevention program. Controls refused due to lack of interest or lack of time. One hundred and one students participated in the program group and 158 participated as controls. There were several significant differences between the groups with program students considered "more distressed". Retention was 79.3% for the program group and 81% for the control. An additional 71 students were enrolled in a two semester program, not reported here.

School faculty taught the *RY* curriculum was as an elective, personal growth class. Students met daily for 55 minutes for a full semester. Students took the class for credit and received grades. The teacher-student ratio was no greater than 1:12. Teachers had varied backgrounds ranging from social studies, math, ESL, health and photography.

Criteria deemed important for selection to teach the course were that the teachers: 1) were skilled in expressing support and establishing therapeutic teacher-student relationships with high-risk youth; 2) had a strong desire to teach the class and work with high-risk youth; and 3) participated in teacher training willingly and regularly; and 4) implemented the course as designed. Teachers received three days of training.

Data collection occurred at baseline, posttest (five months) and follow up (seven months). Sources included students' permanent school records on school achievement and attendance and several questionnaires. One questionnaire measured drug use, progression of drug use and drug control problems and consequences. Internal consistency was strong for the full scale (Cronbach's alpha = .89). Another questionnaire consisted of a modified version of the Rosenberg Self-Esteem scale (Cronbach's alpha = .77). A separate measure assessed deviant peer bonding and school bonding.

Trend analysis was used to examine the data and controlled for group differences at baseline. Significant improvements were found in program students in drug control and in improved GPA (but not attendance), in improved self-esteem, and peer and school bonding. The program appeared to stem the progression of drug use, but group differences only approached significance. There were no significant gender differences for the program group.

Critique

This was a well designed study that yielded promising results for a hard-to-reach population. The findings are particularly encouraging given that the program group was significantly disadvantaged going into the study. Long term studies could determine the duration of effects and benefits, if any, of the one semester vs. two semester program.

Evaluation Contact

Leona Eggert, PhD, RN
School of Nursing
University of Washington
Seattle, WA 98052
PH: (206) 543-9455

Resolving Conflict Creatively

Program Description

The *Resolving Conflict Creatively Program* (*RCCP*) is a multi-year program that focuses on conflict resolution and intergroup relations. *RCCP* provides youth with nonviolent alternatives for dealing with conflict and teaches them to apply those strategies to situations in their own lives. Increasing their understanding and appreciation of other students' cultures is also an objective, as is making them aware of the role they play in creating a more peaceful world.

Peer mediators are carefully selected students who receive training in resolving disputes that arise among their peers. The curriculum includes units on peace and conflict, communication, dealing appropriately with anger, solving conflicts creatively, cooperation, affirmation, preventing prejudice and celebrating differences, equality, peacemakers and the future – a positive vision.

The program emphasizes professional development. *RCCP* provides 20 hours of training offered in eight after-school sessions, lasting three hours, for teachers new to the program. Training addresses program philosophy, the curriculum, creative conflict resolution skills such as active listening and mediation, as well as strategies of imparting these concepts and skills to students. Participating schools are eligible for 10 days of staff development, including classroom demonstrations and other support services. Schools also receive parent workshops and leadership training for school administrators.

Services Available

Costs range from $1,000 to $40,000, depending on the size of the school, complexity of the program and length of school commitment. The cost covers curriculum materials and training. For additional fees, schools can order videos, posters and books on conflict resolution.

Implications for Practice

Experts estimate that more than three million crimes occur each year in or near America's public schools. Nationally, more than 400,000 students were victims of violent crime at school in a six-month period and about 270,000 guns are brought into schools daily. Goal 7 of the National Education Goals is to insure that by the year 2000, every school in the United States will be free of drugs, violence, and the unauthorized presence of firearms and alcohol, and will offer a disciplined environment conducive to learning. *Healthy People 2000* objective 7.16 calls for increasing to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolutions skills, preferably as a part of a comprehensive school health education. *RCCP* is one of the largest and longest running conflict resolution programs in the country and offers schools an effective approach to preventing violence and creating more peaceful classrooms.

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Linda Lantieri
Director
Resolving Conflict Creatively Program National Center
163 Third Ave. #103
New York, NY 10003
PH: (212)387-0225 / FAX: (212)387-0510

Resolving Conflicts Creatively

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Evidence of Program Effectiveness

Evaluators studied the 1988-89 implementation of the program. A formative evaluation examined program implementation, satisfaction with program components, impact of *RCCP* on students and teachers, and classroom and school climate.

Information about the implementation and impact of *RCCP* came from surveys of 200 participating teachers and school-based program personnel and administrators' questionnaires. Sixty-five percent of teachers returned completed surveys. The majority of respondents were elementary school teachers with 40.2 percent coming from kindergarten through third grade and 38.5 percent in fourth to sixth grade. When asked which of the three components of the program was most important, equal proportions of respondents (37.4 percent) cited the introductory training sessions and work with staff developers while 25.2 percent indicated that the curriculum was the most important aspect.

Teachers' assessments of the impact of the program on students included: students demonstrated less physical violence in the classroom (71 percent); less name-calling and fewer verbal put-downs (66.3 percent); more caring behavior (77.8 percent); and increased understanding of other students' viewpoints (71.5 percent).

A representative sample of 176 fourth-, fifth- and sixth-grade program students and a comparison group of 219 matched students who did not participate in the program completed a specially designed student achievement test. This 20-item test measured knowledge of the *RCCP* concepts and conflict resolution behaviors. Students who participated in the program scored higher on the achievement test (a mean of 15.03 vs. 12.38) than did the control group. An analysis of students' responses showed that 80 percent of program participants could correctly define the word "conflict" compared to 65 percent of the controls. Two-thirds of program participants identified a key part of "active listening" as "keeping eye contact with the other person," compared with only 32 percent of control students.

Sixty-seven percent of program students agreed that it is possible for everyone to win when a conflict arises compared to 35 percent of control students.

The evaluation also assessed the student mediation training offered in five schools. Of the teachers, advisors, students and mediators surveyed, 98.2 percent indicated that the mediation component gave children an important tool for dealing with everyday conflicts. Of the 143 student mediators who completed surveys, 83.7 percent responded that being a mediator gave them skills they could use their whole lives.

Suggestions on how to improve the program included more staff development time and more training. In particular, teachers said they would like additional assistance in integrating conflict resolution concepts into other classroom lessons and facilitating monthly school meetings. An overwhelming proportion of respondents proposed parental involvement be a part of the program in order for children to receive consistent reinforcement of the skills they learn in school.

Critique

Although *Resolving Conflict Creatively Program* is one of the oldest conflict resolution programs in the country, the only available data was formative evaluation data. This very promising program would benefit from a more rigorous evaluation involving a comparison group, outcome measures and pre/post data. Measures might include information from disciplinary reports, school suspensions and students' self-reported behavior changes.

Evaluation Contact

Metis Associates, Inc.
26 Broadway
New York, NY 10004
PH: (212) 425-8833 / FAX: (212) 480-2176

School Development Program

Program Description

The *School Development Program* (*SDP*) was started in 1968 by James P. Comer, MD, of the Yale Child Study Center. *SDP* is a primary prevention program that uses a systems perspective involving a partnership between universities, school districts and schools to help schools become more responsive to the needs of children, particularly minority low-income students. Over 600 schools in 26 school districts in 23 states have adopted this comprehensive program. The *SDP* focuses on improving the school's social environment by establishing mechanisms and operations that are sensitive to the physical, cognitive, psychological, language, social and ethical development needs of individual students, while maintaining high standards for school performance and expectations for student success. Three principles guiding the program are a no-fault approach to problem solving, consensus decision making and collaboration.

SDP requires a total school commitment and expanded resources, including an in-district facilitator dedicated to the program. It uses three school-level teams – School Planning and Management Team, Mental Health Team and Parent Program. The School Planning and Management Team serves as the central organizing body in the school and develops and monitors a comprehensive school plan that includes academic, social and staff development goals. The building principal leads the School Planning and Management Team, which also includes teacher and parent representatives and a Mental Health Team member. The Mental Health Team includes staff with child development and mental health knowledge and experience, such as guidance counselors, school psychologists and school nurses. The Mental Health Team meets weekly to address general school concerns, as well as issues regarding individual students and teachers. The Parent Program encourages parental involvement in school activities such as policy and management issues.

SDP modifies dysfunctional elements of a school's social environment by developing a comprehensive school plan that delineates social and academic goals and activities to achieve the goals, providing staff development that addresses the goals and activities and monitoring progress toward achieving the goals on an on-going basis, making modifications as needed. Staff development often involves increasing sensitivity and responsiveness to the social context in which students live and the school functions.

In order to support school districts independent of the Yale Child Study Center, the program has developed partnerships with university education programs, state departments of education and other institutions that can provide nearby schools with needed support. As part of a consortium, the developers are working on a professional preparation program to prepare teachers for work in urban schools. Other projects include developing "how to" videotapes and manuals for training and implementation assistance.

Services Available

SDP trains local facilitators who work under their local superintendent and receive a modicum of direct support from the Yale Child Study Center or another collaborating institution. Orientation workshops are available for parents, teachers and administrators, as are a variety of products including videos, books and audio tapes.

Implications for Practice

Systemic, school-wide approaches can help create conditions that improve the likelihood that at-risk students will develop well socially and academically. Programs such as the *SDP*, that are comprehensive, culturally responsive and engage families, are likely to improve academic and behavioral outcomes for minority low-income children. While no program will meet all the needs of every student, this primary prevention program could enable schools to target further preventative efforts, if necessary.

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Edna Negron
Implementation Coordinator
School Development Program
55 College St.
New Haven, CT 06510
PH: (203)737-1075

School Development Program

	E	Design
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Evidence of Program Effectiveness

Two studies have explored the long-term impact of the *SDP* on achievement and mental health adjustment including self-concept and behavior. The first, a retrospective study, involved 44 middle school students who attended the two original program schools and 18 students who attended two non-program schools. Because of the retrospective nature of the study, students were not randomly chosen and took no pretests. The research staff interviewed randomly selected students who had obtained parental consent during two individual sessions at the child's school. During the first session a Youth Child Study Center staff person had the child complete the Tennessee Self Concept Scale and administered the Social Adjustment Scale interview. During a second session on the following day, children completed the Woodcock-Johnson Battery (Brief Scale). Each session took approximately 45 minutes. Parents completed a Child Behavior Checklist for each child and teachers provided additional information. Research staff also collected data from report cards, test scores and attendance records. Results found statistically significant differences in math and reading achievement, but not on the behavioral or mental health scores.

The second study used a quasi-experimental design to follow a randomly selected sample of 253 predominantly black children in grades K-6, their parents and teachers. One hundred fifty-three students (60 percent) attended program schools and 100 students (40 percent) attended non-program schools. Data collection replicated procedures used in the first study except participants attended only one session and completed fewer student measures (the Tennessee Self-Concept Scale and a student behavior questionnaire). Other measures included a standardized achievement test (the California Achievement Test), report card grades, parents' assessment of school climate and child behavior, teacher questionnaire on student attitude and behavior and teacher assessment of school climate.

Results showed significant gains in reading and math for students in program schools, as well as statistically significant positive differences in students' classroom behavior, group participation and attitudes. Parents felt more involved with the school; some even returned to school and obtained their high school diploma or vocational training. Teachers reported increased feelings of efficacy and job satisfaction and rated their school climate as more positive, as did students. Teachers rated program students more highly than controls on classroom behaviors, group participation, and attitude. Parents' and teachers' assessments of children's behavior were more similar than students' assessments of their behavior. For different grade levels, different combinations of behavioral, attitudinal and achievement data discerned between students in program and control schools.

Critique

SDP's objectives are ambitious, but evaluations have demonstrated effectiveness in schools committed to change. Data are scarce on student outcome measures for health-related risks. Some evaluations of the *SDP* done in the 1980s used aggregate student performance data to compare program and non-program schools. There is no evidence of comparability across groups prior to program implementation. Aggregate data found significant gains in reading and math performance, and in some cases language, for *SDP* schools, as well as improved student attendance, classroom behavior, group participation, attitude toward authority and self-concept. Studies of randomly selected students in matched schools found significant differences in academic achievement between students in *SDP* and non-*SDP* schools. The data however are dated.

Evaluation Contact

Christine Emmons, PhD
School Development Program
53 College St.
New Haven, CT 06510
PH: (203)737-4004 / FAX: (203)737-4001

Seattle Social Development Project

Program Description

The goal of the *Seattle Social Development Project* (*SSDP*) is to prevent risky behavior in youth, particularly delinquency and drug abuse, by improving parent-child communication and changing teachers' classroom management practices. Developed in 1987 by the Social Development Research Group at the University of Washington, *SSDP* addresses the needs of urban students in elementary grades who exhibit characteristics of conduct disorder, rebelliousness and peer rejection. A new version of the project is entitled *Raising Healthy Children.*

The program is based on the social development model which suggests that individuals are less likely to engage in antisocial activities if they have strong bonds to family and school. Bonding is a protective factor composed of three elements: a positive emotional feeling toward others, a sense of investment with others and a belief in the general values held by important others.

The program includes activities for students, teachers and parents. Children learn social and cognitive skills in the first through fourth grades. In small, mixed-ability cooperative groups, they learn interpersonal communication, decision-making skills, negotiation and conflict resolution techniques. Teachers use proactive classroom management techniques to establish a learning environment where expectations are clear and explicit. This promotes positive student behaviors and minimizes disruptions. In addition, teachers use "interactive teaching" and assume that all students can succeed under appropriate instructional conditions.

The *Catch 'Em Being Good* curriculum contains seven sessions for parents with children in first and second grade. Parents learn how to help their children resist peer pressure, apply consistent family management practices and minimize conflict in the family through modeling of skills, role play, feedback and homework practice assignments. *How to Help Your Child Succeed in School* provides four sessions for parents of second and third graders. It seeks to improve communications and academic support in the home.

The teacher training component consists of several days of in-services throughout the school year. Topics include proactive classroom management (August), interactive teaching (October) and cooperative learning methods (February). It focuses on preventing academic failure, early intervention in cases of inappropriate conduct and increasing classroom involvement.

Services Available

Contents of the curriculum kit include a leader's guide, companion videos and family activity books. Optional supplemental materials include audio tapes on risk factors and an "ethnic adaptation guide," which helps schools adapt materials to various ethnic groups.

Implications for Practice

The factors that put adolescents at risk for drug-related problem behaviors include insufficient parental supervision, poor communication and a lack of problem solving and social interaction skills. Poorly communicated expectations for behavior and inconsistent discipline play a part as well. Substandard school performance and inadequate child-school bonding increase the probability of dropping out. The *SSDP* is a "universal" prevention approach that addresses the whole school community, not just particular students-at-risk or a particular risk factor. *Healthy People 2000* objective 4.13 calls for providing educational programs on alcohol and other drugs, preferably as part of a comprehensive school health education.

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Karl Hill, PhD
Project Director
Social Development Research Group
146 North Canal St., Suite 211
Seattle, WA 98103-8652
PH: (206) 685-1997 / FAX: (206) 543-5407

Seattle Social Development Project

✓	E	Design
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Evidence of Program Effectiveness

The Seattle Social Development Project followed 1,053 multi-ethnic urban students who entered the first grade in eight Seattle Public Schools. Forty-six percent of the sample were white, 52 percent were male and 93 percent of students were 10 or 11 years of age. Thirty-eight percent of the students qualified for the National School Lunch/School Breakfast Program in the fall of the fifth grade.

Children entering first grade in 1981 were assigned to either a program or control classroom on a random basis. In 1985, when the initial students entered the fifth grade, the sample was expanded to include all fifth-grade students in 18 Seattle elementary schools resulting in a control condition, a full treatment condition (all six years) and a late treatment condition (fifth and sixth grade only). The project examined the effects of modified teaching practices in classrooms and parent training program.

In first to fourth grade, program teachers used instructional methods that included proactive classroom management, interactive teaching and cooperative learning. First-grade teachers provided students with cognitive problem-solving instruction using a curriculum by Shure and Spivack. Parents of 43 percent of the program students, in first, second and third grade, attended at least one parenting class. Project staff provided parenting workshops in collaboration with local school and parent councils. Project staff and school principals observed teachers and provided feedback on the use of the project's teaching techniques. Teacher observations with feedback occurred approximately once every three weeks. Control teachers and parents did not receive any training, however, control teachers were observed over four class periods in the fall and spring each year to document teaching practices.

Nine hundred nineteen students (87 percent) provided data during the 1985 fall, when the initial students entered the fifth grade and 608 (58 percent) completed surveys again at the end of sixth grade. A self-report survey administered in the classroom to all consenting study participants measured perceived opportunities, skills, and rewards in the family and classroom, peer interactions, and problem behavior including substance use and delinquent behavior.

By the end of the second grade, boys in program classrooms were significantly less aggressive than boys in control classrooms. By the beginning of fifth grade, program students were significantly less likely to have initiated delinquent behavior and alcohol use than control students. By the end of sixth grade, boys from low income families had significantly greater academic achievement, better teacher-rated behavior and lower rates of delinquency than low income comparison students. Low-income program girls, in sixth grade, were significantly less likely to use tobacco and tended toward less alcohol and marijuana use than low-income control girls. On measures of family interaction, students who received the program reported significantly more proactive family management by their parents ($p<.02$), as well as greater family communication ($p<.02$) and involvement ($p<.05$) than the control students. In addition, program students reported greater bonding to family ($p<.02$) than control students. On measures of school bonding, program students perceived school as more rewarding ($p<.02$) than did controls. In addition, program students were more attached ($p<.02$) and committed ($p<.02$) to school than control students.

Critique

This is a well designed study that sheds some light on the effectiveness of programs that address common risk factors for both delinquency and drug abuse and seeks to build protective factors in the home and school. Findings suggest that the intervention can be implemented with enough fidelity to achieve significant differences in social bonding to family and school during the early elementary grades. In theory, the *Seattle Social Development Project* should reduce substance abuse and delinquent behaviors in adolescence. Sixth-grade data shows weak tendencies in that direction. Additional longitudinal data could confirm the theory.

Evaluation Contact

J. David Hawkins, PhD
Principal Investigator
Seattle Social Development Project
University of Washington
School of Social Work
Seattle, WA 98195
PH: (206) 685-1997 / FAX: (206) 543-5407

Social Competence Promotion

Program Description

The *Social Competence Promotion Program for Young Adolescents* (*SCP*) was designed by Roger Weissberg and his colleagues at Yale University in collaboration with the New Haven, Conn. public schools over a period of 10 years. *SCP* is one component of a much larger K-12 effort known as the *New Haven Social Development Project.*

SCP uses a social-information processing framework to promote social competencies such as self-control, stress management, responsible decision-making, social-problem solving and communication skills. Other objectives include enhancing the quality of communication between school personnel and students and preventing antisocial and aggressive behavior, substance use and high-risk sexual behaviors.

SCP is a 45-session, classroom-based program in three modules. The first module has 27 lessons and teaches students a six-step problem-solving process. The steps are: 1) stop, calm down and think before you act; 2) say the problem and how you feel; 3) set a positive goal; 4) think of lots of solutions; 5) think ahead to the consequences; and 6) try the best plan. Activities use the six steps and take place in a 45-minute class period. Scripted lesson plans include direct instruction, class discussions of real-life problems, role play, cooperative and competitive games, videotapes and other visual aids and materials. The second and third modules consist of nine sessions each. They use a similar format and apply the six steps to the prevention of substance use and high-risk sexual behavior.

SCP integrates Hawkins's Protective Factor Model that suggests that even effectively providing these skills will fall short unless the people and systems with which young people interact are also addressed. To foster the application and generalization of *SCP* concepts to daily life, teachers use the problem-solving model in situations other than formal lessons, guiding and encouraging students to use the strategies beyond the classroom.

Several schools have restructured their in-house suspension program to include the steps as a central theme. Although young adolescence encompasses the ages 10-15, *SCP* is most often used in regular, special and bilingual education in sixth grade.

Services Available

Training manuals for the three *SCP* modules cost $80 if ordered together, $90 if purchased separately. Fax purchase requests to (312) 355-0559 or mail them to the address below. All orders must be prepaid.

Implications for Practice

Young adolescence is a time of predictable stressors and dramatic life changes. Many of these involve resolving conflicts with peers, choosing appropriate friends, negotiating increased independence from parents and other social pressures. When a youth has insufficient coping mechanisms to negotiate these daily challenges, the result is often multiple high-risk behaviors that can interfere with development. *SCP* addresses common risk factors for negative social and health outcomes. This type of coordinated program fits the definition of comprehensive school health education as defined by the National Invitational Conference on Comprehensive School Health: "a planned program of experiences for students in grades K-12 which teaches important information, skills and positive attitudes toward the promotion of health and well-being. The curricula include instruction in the essentials of physical, mental, social and emotional health."

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Roger P. Weissberg, PhD
University of Illinois at Chicago
Department of Psychology
1009 Behavioral Sciences Bldg.
1007 West Harrison St.
Chicago, IL 60607-7137
PH: (312) 996-3036 / FAX: (312) 413-4122

Social Competence Promotion

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Evidence of Program Effectiveness

A 1992 study evaluated an earlier version of *SCP* containing 20 lessons in an urban and suburban middle school. Classes were stratified within ability groupings and randomly assigned to program or control conditions. The urban sample consisted of 72 program and 134 control students (90 percent African American, 8 percent Hispanic, 2 percent mixed ethnic origin). The suburban sample consisted of 37 program and 39 control students (99 percent White, 1 percent was Hispanic). The curriculum was taught by both master's-degree level health educators and the classroom teacher during two 50-minute class periods per week over a 15 week period. They received 12 hours of training prior to implementation and weekly on-site visits from program developers. Six units covered stress management, self-esteem, problem solving, substances and health information, assertiveness and social networks.

Students took a battery of confidential surveys at baseline and posttest. Dependent measures were coping skills, social and emotional adjustment, attitudes toward smoking and drinking, intentions and use/abuse of alcohol and drugs. Cronbach's alpha of internal reliability (range .71-.82) was acceptable for all measures but one, which was not used in the final analysis. Some of the data was coded by two independent raters with a satisfactory level of agreement for non-redundant responses (kappa=.89) and for effectiveness (r=.81). After the program, students also completed a program satisfaction questionnaire. Attrition was less than 20 percent in both groups. Teachers rated the students on a five-point social and emotional adjustment scale that considered constructive conflict resolution with peers, impulse control, popularity and assertiveness with adults.

Data analysis used repeated measures, multivariate analyses of variance (MANOVAs with $p<.05$), followed by univariate ANOVAs with the pretest scores as covariates. Findings revealed that the program students, relative to the control group, significantly improved in both the quantity and effectiveness of solutions generated in response to hypothetical peer pressure situations and the quantity and adaptiveness of stress management strategies used when anxious or upset. Teachers' ratings of program students also significantly improved on three of the four measures in some but not all classes.

Program students significantly improved in their feelings of problem-solving efficacy compared to the controls and this improvement was greatest among urban students.

Compared to the controls, program students were significantly less likely to intend to use beer and hard liquor despite increasing intentions in both groups pre to post to use cigarettes, marijuana and wine. There were no significant differences in the reported frequency of substance use, however changes in reported excessive use was significant. Control students increased their frequency of having three or more drinks on a single occasion, frequency of having too much to drink, and the amount of beer, wine, or liquor they usually consumed on one occasion whereas program students' behaviors did not change. Student satisfaction with the program was extremely high, greater than 90 percent, and students reported that they used the skills in their daily life.

Later evaluations of a 16-session version of the program with 238 adolescents in fifth to eighth grade in urban middle schools found similar results. Relative to the controls, program students improved their problem solving abilities and pro-social attitudes toward conflict resolution. Students showed the greatest improvements in classes where the program was implemented most effectively.

Critique

Although these positive findings replicated earlier studies, some limitations include bias from self-report and inability to distinguish particular factors that contributed to positive outcomes in some classes but not others across diverse settings. Use of objective measures such as incidence of disciplinary actions to provide alternative outcome measures could strengthen the study as well as long-term follow-up studies to determine the duration of effects.

Evaluation Contact

Roger P. Weissberg, PhD
University of Illinois at Chicago
Department of Psychology
1009 Behavioral Sciences Bldg.
1007 West Harrison St.
Chicago, IL 60607-7137
PH: (312) 996-3036 / FAX: (312) 413-4122

Social Decision Making and Problem Solving

Program Description

The University of Medicine and Dentistry of New Jersey-Community Mental Health Center at Piscatway and Rutgers University worked jointly with local schools to develop the *Social Decision-Making and Problem Solving* (*SDMPS*) Program beginning in 1979.

The purpose of *SDMPS* is to develop children's social competence and general decision-making skills to cope with social stress from peers, make sound choices and avoid self-destructive behaviors. Classroom teachers implement the program in three phases, usually in one session per week, more frequently for children in special education.

Children in grades 1-3 learn self-control and social awareness skills including listening and concentrating, following directions, remembering, resisting provocations, avoiding provoking others and self-calming in addition to selecting friends and showing caring. Children in grades 4-6 learn the self-control and social awareness skills plus an eight-step, decision-making process. Facilitative questioning techniques help children become independent thinkers able to transfer and generalize skills to real life problems.

In 1988, the National Mental Health Association awarded *SDMPS* a Lela Rowland Prevention Award as an outstanding example of an effective prevention program. The U.S. Department of Education designated it as a validated program of the National Diffusion Network in 1989 and revalidated it in 1995 as an exemplary program. *SDMPS* has trained more than 2,500 teachers from 400 public and private sites in 20 states.

Services Available

Materials include an awareness video, a program newsletter and a leaders guide for conducting parent meetings. The administrator's manual explains the program's theoretical and philosophical rationale and includes all the lessons for an elementary school program, troubleshooting strategies for dealing with problems, a program monitoring and evaluation plan, and reproducible handouts, posters and worksheets. A teacher's guide contains lessons needed to teach a particular grade and classroom posters.

Three days of training are available for classroom teachers and a site leadership committee on site or at a regional training center. Technical assistance is available for evaluation and program implementation.

Implications for Practice

Children who have problems interacting with others are more likely to drop out of school and engage in delinquent or self-destructive behaviors. How well a child gets along with other children is an important predictor of adult functioning. Social and emotional competency facilitate learning and academic achievement. *SDMSP* helps students develop social competence, learn effective skills that students can use in many academic and life situations and acquire negotiation and stress management skills.

Audience	
P	
K[3]	✓
4[6]	✓
M	
H	
K[12]	
S	✓

Locale	
R	
U	
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M	✓

Level	
Cl	✓
B	
D	
Co	

Components	
C	✓
St	✓
Pe	
Pa	✓
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	✓
N	
B	✓

John Clabby, PhD, Director
Linda Breune, Senior Consultant
Social Problem Solving / Decision Making Program
UMDNJ, University Behavioral Health Care
240 Stelton Road
Piscataway, New Jersey 08854-3248
PH: (908) 235-4939 / FAX: (908) 235-5115

Social Decision Making and Problem Solving

	E	Design
✓	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
✓	Qn	
	B	
✓	F	Type
	S	
✓	O	
✓	P	

Evidence of Program Effectiveness

A 1981 study, conducted in a lower-middle to middle-class suburban community with a predominantly white, blue-collar population assessed the effectiveness of teacher training. Eight teachers responded to a series of hypothetical school-based, student interpersonal problem situations. Following training, teachers increased their use of strategies to foster problem-solving skills among student compared to the control group ($p<.001$). A 1993 study used the same instrument with 49 teachers and confirmed the findings with even greater magnitude.

To determine whether children exposed to the program improved their social decision-making and problem solving skills, evaluators compared pre and post scores on a criterion-referenced, developmentally-appropriate instrument called "Getting Along with Others." Compared to control students, significantly more program students in the third grade could provide specific strategies for paying attention and could identify specific symptoms of personal stress and specific strategies to gain control of stressful situations. Teachers reported that students in the program made significant gains in self-control, sensitivity to others, positive behavior and peer acceptance. They required less teacher time to deal with problems compared to students who did not get the program. A replication study in 1993 conducted with urban, rural, minority and low-income students of varying academic abilities found similar results.

In other studies, 344 fourth-grade students responded to "The Group Social Problem Solving Assessment," (GSPSA) a reliable, criterion-referenced, developmentally-appropriate instrument with three sub-scales that measure interpersonal sensitivity, problem analysis and specificity of planning. The instrument's coefficient alphas were approximately .75. Following training, the fourth grade program group compared to the control group demonstrated significantly better knowledge of problem solving concepts ($p<.01$), with particularly significant gains in sensitivity to others' feelings ($p<.01$) and understanding of consequences ($p<.05$).

To determine the persistence of training effect, evaluators compared students in middle school who had received complete training in elementary school to students who had received partial training and no training using the GSPSA and "The Survey of Middle School Stressors." The instrument discriminated between these three groups ($p<.04$). This instrument has an internal consistency coefficient greater than .90 across different samples and has predicted Piers-Harris self concept scale scores. Additional studies confirmed that these effects persist through high school as measured by the National Youth Survey of Antisocial and Delinquent Behaviors and the Youth Self-Report Rating Scale.

Critique

Multiple studies of this program have demonstrated that training improves teachers' ability to facilitate children's social decision making and problem solving; students' exposure to the program improves their social decision making and problem-solving abilities; and the effects persist as students transition to middle school. Students in high school who received even partial training in elementary school had higher levels of positive pro-social behavior and decreased antisocial and self-destructive behavior than control students.

Evaluation Contact

June Hampson, PhD
UMDNJ University Behavioral HealthCare
240 Stelton Road
Piscataway, New Jersey 08854-3248
PH: (908) 235-4939 / FAX: (908) 235-5115

SPARK PE

Program Description

Over a five-year period in the late 1980s, a team of researchers and educators from San Diego State University developed *Sports, Play and Active Recreation for Kids* (*SPARK PE*) with funding from the National Heart, Lung and Blood Institute. The goal of *SPARK PE* is to increase elementary-aged children's physical activity levels both in and out of school. In 1994, the National Diffusion Network of the U.S. Department of Education validated *SPARK PE* through its program effectiveness panel. Over 150 schools in eight states and territories had adopted the program as of 1996.

SPARK PE seeks to improve students' physical activity, fitness, skills and enjoyment of physical activity as a means to reduce major risk factors for cardiovascular disease. Developmentally appropriate lesson plans designed for easy implementation maximize participation during physical education class time. The curriculum calls for a minimum of three physical education classes a week through the entire school year. Activities promote health-related fitness (i.e., development of muscle strength and endurance, cardiovascular endurance, flexibility, locomotor and non-locomotor skills) and skill-related fitness (i.e., manipulative and sport-related skills). In addition to lesson plans for physical education, the program includes self-management curricula to help upper-elementary students manage their own physical activity. The self-management lessons call for mobilizing parents and peers to create a supportive social environment that helps students maintain physical activity outside of school and after transition to middle school. A key to *SPARK PE* is training for those who will implement the program, either classroom teachers or physical education specialists.

Services Available

Individual curricula cost $59.95 for physical education materials (grade K-2 or grade 3-6) and $49.95 each for self-management materials (grade 4-5 or grade 5-6). The set of all four costs $175.95. The cost of training varies, with fifteen hours needed for the physical education curricula and six hours for the self-management curriculum.

Implications for Practice

School physical education is the primary institution charged with promoting physical activity in children. Although 97 percent of elementary children participate in school physical education, few existing physical education programs provide sufficient levels of moderate to vigorous activity to promote cardiovascular endurance. *SPARK PE* promotes lifetime fitness using clear, practical, teacher-friendly lessons that progressively improve the major components of physical fitness. The lessons help teachers by reducing planning time, facilitating class management and organization, and improving teaching techniques. *SPARK PE* achieves the level moderate to vigorous activity in physical education classes specified by *Healthy People 2000* objective 1.9.

Audience	
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K[3]	✓
4[6]	✓
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H	
K[12]	
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Locale	
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U	
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M	✓

Level	
Cl	✓
B	
D	
Co	✓

Components	
C	✓
St	
Pe	✓
Pa	✓
M	
P	
Sk	✓
Se	

Emphasis	
K	
A	
N	
B	✓

Paul Rosengard, Educational Services Director
Thom McKenzie, PhD, Co-Director
SPARK PE
6363 Alvarado Court, #250
San Diego State University
San Diego, CA 92120
PH: (619) 594-4815, (800) SPARK-PE / FAX: (619) 594-8707
e-mail: sparkpe@mail.sdsu.edu
Internet: http://www.foundation.sdsu.edu/projects/spark/index.html

SPARK PE

✓	E	Design
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✓	I	Analysis
✓	G	
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	C	
	M	
	QI	Data
✓	Qn	
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✓	P	

Evidence of Program Effectiveness

Approximately 1,400 fourth-grade students (82 percent White, 12 percent Asian/Pacific Islander, 4 percent Hispanic, 2 percent African American) in seven elementary schools in one school district, participated in the study. Schools were stratified by percentage of minority and randomly assigned to one of three conditions. Within strata, three schools served as controls using their standard physical education program, two received the program delivered by trained classroom teachers and two received the program led by physical education specialists. All students participated and 98 percent permitted measurement during the two-year study.

Certified assessors unrelated to the program used adaptations of the FITNESSGRAM protocols to obtain fitness measures in the fall and spring of each year for two years. They measured cardiorespiratory endurance, muscular strength and endurance, and flexibility by the sit and reach test. They also estimated body composition using skinfold, along with height and weight measures. Inter-observer reliability was .87 for triceps and .93 for calf skinfolds. Subsequent analyses adjusted for baseline differences in mile-run times and number of sit-ups by age and gender. For each fitness variable, evaluators used repeated measures modeling to estimate the rate at which a student's measurement changed per month during the first year of intervention. To test for differences in treatment effect, the slope of each student's estimated rate of change with "intercepts" of the student's baseline measurements, then added covariance by condition to the analysis of the slopes.

To obtain information on both the quality and quantity of instruction provided during physical education lessons, independent observers used the System for Observing Fitness Instruction. Measurements occurred during randomly selected weeks throughout the study. Observers conducted unannounced measurement visits unobtrusively as possible and interacted little with teachers. The observers measured activity level of randomly selected students, lesson context and teacher behavior every 20 seconds. Inter-observer reliability was 93.7, 96.1 and 89 percent, respectively, for student activity, lesson context and teacher behavior. One-way ANOVA used mean scores of aggregated lessons with classes/teachers as the unit of analysis.

Students in schools where physical education specialists implemented *SPARK PE* made significant gains in cardiovascular endurance over the other two groups. When classroom teachers implemented the program, students reduced skinfold thickness the most. Sit-up measures improved the most in specialist-led groups, but teacher-led groups also showed gains over the controls. Teacher-led groups, however, decreased in flexibility with respect to the other two groups and no groups improved in strength measures. Another analysis of the data revealed no differences in body composition for any group.

Process evaluation revealed that classroom teachers trained to implement *SPARK PE* provided significantly more physical education of a higher quality than did control teachers. Differences included frequency and length of classes; minutes children engaged in moderate-to-vigorous activity, fitness activities and skill drills; and minutes and proportion of class time teachers spent being instructionally active. Trained physical education specialists achieved even better outcomes than the trained classroom teachers. Students reported enjoying the activities and teachers evaluated *SPARK PE* highly.

Critique

This study involved randomization of treatment by schools, very low attrition and implementation by both physical education specialists and classroom teachers reflecting the reality in elementary schools. Process and impact evaluation demonstrated effectiveness in increasing activity level during physical education classes, students' cardiorespiratory endurance and ability to perform sit-ups. *SPARK PE* did not show convincing evidence of increasing students' arm strength, flexibility or leanness. No longitudinal studies show whether students maintain gains later in life.

Evaluation Contact

Thom McKenzie, PhD
SPARK PE
6363 Alvarado Court, #250
San Diego State University
San Diego, CA 92120
PH: (619) 594-4815, (800) SPARK-PE
FAX: (619) 594-8707

Straight Talk About Risks

Program Description

Following two years of research and development, the Center to Prevent Handgun Violence implemented *Straight Talk About Risks* (*STAR*), a gun violence prevention program for school-aged youth (preK-12) in 1992. *STAR*'s premise is that all U.S. children and teens are at risk for gun injury and death. *STAR* helps youth develop skills for victim prevention and managing problems such as conflict and peer pressure. Recently, *STAR* joined with Converse, Inc. and its athlete spokespersons to create *The Converse STAR Team Program*, which communicates youth-generated alternatives to gun violence through public service announcements, prevention brochures and leadership contests.

The *STAR* curriculum includes activities that can fit into health education and violence prevention programs, as well as traditional subject areas such as language arts or science. The pre-kindergarten to second-grade activities help students with conflict resolution, identification of safe places, and making safe choices. Activities for third through fifth grade help them learn decision-making skills and conflict resolution strategies. Activities also address distinguishing between real-life violence and those in the media, alternatives to gun violence, and grief and loss. At the sixth- through eighth-grade level, activities help students understand anger and conflict, including trigger actions and methods of de-escalating conflict. The ninth- to 12th-grade activities incorporate group work, use of reference materials and making presentations to teach how gun violence can impact lives and change society.

The Center to Prevent Handgun Violence is a national, nonprofit education, research and legal action organization, chaired by Sarah Brady. Over 77 municipalities, including New York, Los Angeles and Miami have used *STAR*.

Services Available

A review copy of the 200-page curriculum guide, available in both English and Spanish, costs $13.90. *STAR* materials include skill-building activities, posters, handouts and awareness – materials that promote parent and community involvement; bibliographies; video presentations; staff development training materials and a national guide of complementary violence prevention programs. The Center to Prevent Handgun Violence provides: 1) an initial two-hour orientation session for school administrators, principals and parents; 2) a six-hour training session for teachers, guidance counselors, parents and others regarding program implementation; 3) technical support via site visits by Center staff, telephone or fax. The program is funded through private and public grants. Costs for schools vary according to need.

Implications for Practice

Every day, 16 children in the United States die in gun homicides, suicides and unintentional shootings. Many more suffer injuries, some of which last a lifetime. Of the youth who live in high crime areas, 35 percent report carrying a gun to school. Several *Healthy People 2000* objectives (7.3, 7.10, 7.11) calls for reducing weapons-related violence.

Audience	
P	
K^3	
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K^{12}	✓
S	

Locale	
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U	
S	
M	✓

Level	
Cl	✓
B	
D	
Co	✓

Components	
C	✓
St	✓
Pe	
Pa	
M	✓
P	
Sk	✓
Se	

Emphasis	
K	✓
A	✓
N	✓
B	✓

Nancy Gannon
Director
Education Division
Center to Prevent Handgun Violence
1225 Eye Street, NW, Suite #1100
Washington, DC 20005
PH: (202) 289-7319 / FAX: (202) 408-1851

Straight Talk About Risks

Design: [ ] E [✓] Q

Analysis: [ ] I [ ] G [✓] B [ ] D [ ] C [ ] M

Data: [✓] QI [ ] Qn [ ] B

Type: [✓] F [ ] S [ ] O [✓] P

Evidence of Program Effectiveness

The New Jersey State Department of Education in partnership with the Center to Prevent Handgun Violence conducted a demonstration project featuring the *STAR* program during the 1992-93 school year. Middle schools in 21 municipal districts volunteered to participate in the project and involved 110 educators and more than 7,000 students. Students came from rural, suburban and urban communities. The process evaluation of the program's implementation used a survey and a case study approach.

School personnel received orientation and those involved in implementation attended a six-hour training session. Center personnel visited school sites to observe classroom implementation and conducted structured interviews regarding program implementation plans or concerns. The 14 structured interviews revealed that seven schools had incorporated *STAR* activities into existing prevention programs such as *Drug Abuse Resistance Education* (*DARE*), or health or life skills programs. An additional two schools used *STAR* as a stand-alone prevention program. One school planned to offer the program as a stand-alone course for seventh and eighth grade. Another school offered an "Awareness Day" to students using elements of the *STAR* curriculum prior to beginning full program implementation. Two schools reported encountering resistance to *STAR* from principals, faculty or with members from the school board or community. Evaluators concluded that for effective implementation, program advocates needed to spend time and resources publicizing *STAR*'s prevention messages to school and community leaders in order to offset concerns that *STAR* is a politically or socially charged program.

At the end of the school year, 51 respondents (61 percent of the education professionals who participated in the program) completed surveys. Of the five questions that pertained directly to *STAR* all received a "favorable" response with the exception of: "The *STAR* program was well received by my school community, including parents." Forty-seven percent were noncommittal, 10 percent disagreed and 43 percent agreed.

Qualitative data included comments of praise, constructive criticism and innovative ideas. In several cases, schools utilized *STAR* activities and resources and then continued with their own "booster" programs in school and the community.

Evaluation materials provided reported on a formative evaluation conducted in Los Angeles by The Education Development Center (EDC). EDC, under contract, found gains in knowledge, attitude and skills development among third- to fifth-graders. Among sixth- to eighth-graders, EDC found knowledge, attitude and skills gains in *STAR* schools that were less than those in the control schools; changes for ninth- to 12th-graders were nonsignificant. The evaluation materials provided no specific information about the research design, instruments, data collection or analysis and no specific data regarding this study.

Critique

The process evaluation of the *STAR* program was informal and provided limited information due to its small sample size and lack of control groups. The Center plans to conduct in-depth student outcome research as phase three of a multi-year evaluation process. The prevention of gun violence among youth is a complicated and challenging issue, especially in large urban public school districts. *STAR* shows promise as a popular program that addresses a critical health issue.

Evaluation Contact

Alicia Horton, JD, MPH
Associate Director
Education Division
Center to Prevent Handgun Violence
1225 Eye Street NW, Suite 1100
Washington, DC 20005
PH: (202) 289-7319 / FAX: (202) 408-1851

Students Taught Awareness and Resistance

Program Description

Students Taught Awareness and Resistance (STAR) is the instructional component of the *Midwestern Prevention Project (MPP)*, a multi-year drug abuse prevention program. Components of the *MPP* include programs for schools, parents, community organizations, and the mass media. By targeting sixth and seventh graders, the program strives to reduce the use of gateway drugs such as tobacco, alcohol and marijuana in early adolescence and, in later years, other illicit substances.

Grants from the National Institute of Drug Abuse supported development and evaluation of the *MPP*. The program derives from social learning theory, theories of behavior change and developmental transition, transactional and systems theories of environmental change and communication theories of program delivery in communities. The entire early adolescent population of the Kansas City, Mo. metropolitan area has participated in the program since September 1984. The school component, called *STAR*, consists of 10 sessions that emphasize resistance skills training and counteractive drug use influences. *STAR*'s topics include psychosocial consequences of drug use; drug use prevalence; recognizing and countering adult, media and community influences; resistance to peer and environmental pressures; assertiveness; problem solving; and publicly committing to substance avoidance. It also includes five homework activities involving interviews and role plays with family members.

The program can be delivered in health, science or social studies classes by trained teachers. It includes modeling, peer feedback and practice in and out of class. The mass media component of the program includes news clips, commercials, talk shows, press conferences and a student video contest. The parent component focuses on positive communication skills and a review of school policies.

Community support activities include organizing a drug abuse prevention task force, awarding and recognizing program participants and promoting school and community policies aimed at restricting drug use.

Services Available

The curriculum component, *STAR*, is in the process of being revised and will be available fall 2000. A social competence/resiliency program for fourth- and fifth-grade students called *Bright STARTS* is being tested and will be available in the near future.

Implications for Practice

Alcohol and drug-free schools are a national education goal. Unfortunately, between 1991-95, 24 to 36 percent of 10th graders reported that they had used an illicit drug during the previous year. The attempted sale of drugs at school increased dramatically from 1992-95. By reducing tobacco and marijuana use among adolescents, *STAR* addresses several *Healthy People 2000* objectives (3.5, 3.10, 4.5, 4.9, 4.10, 4.13). Programs such as *MPP* strengthen the role of schools and communities in drug use prevention by providing a community-wide approach.

Audience	
P	
K[3]	
4[6]	
M	✓
H	
K[12]	
S	

Locale	
R	
U	✓
S	✓
M	

Level	
Cl	
B	
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Components	
C	✓
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Emphasis	
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B	✓

Angela Lappin
Project Manager
Institute for Health Promotion and Disease Prevention Research
University of Southern California
1441 Eastlake Ave. MS44
Los Angeles, CA 90033-0800
PH: (213) 764-0325

Students Taught Awareness and Resistance

✓	E	Design
	Q	

✓	I	Analysis
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	M	

	QI	Data
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Evidence of Program Effectiveness

Researchers from the University of Southern California and the University of Illinois at Chicago began a longitudinal evaluation of *MPP* in the Kansas City Standard Metropolitan Statistical Area in 1984. Sixth- and seventh-grade students from all 50 middle and junior high schools participated (N=5,378). The study collected data from a sample of those students. An equal number of male and female students were sampled, most were White and 78.9 percent were in the seventh grade.

The *MPP* consisted of four components, *STAR*, a parent involvement component, community interventions and use of the mass media. Fifteen schools in Kansas City were randomly assigned to program or control conditions. Program schools received all four components of *MPP*; those in the control condition received only community and mass media components. A total of 65 teachers from 27 program schools implemented *STAR*, the school component of *MPP*. The study assessed *MPP*'s effectiveness for both high and low risk students in the randomly assigned schools with annual measurement through three years after program completion. In addition to testing the program's effects, the study revealed that the major predictors of alcohol, tobacco or marijuana use three years hence were use of alcohol or tobacco in sixth grade, friends' use of drugs, parents' use of drugs and age.

Measures included a student drug use survey administered one-and-a-half months prior to the start of the program and annually for three years, a teacher questionnaire (administered immediately after the program) and a biochemical measure designed to increase the accuracy of self-reported smoking. In addition, a research staff member made random observations in each school and periodic phone calls and meetings with teachers and principals.

A multiple logistic regressional analysis revealed that the program reduced the prevalence of monthly cigarette smoking and marijuana use at the ninth and 10th grade levels three years after program delivery, but had no significant effect on alcohol use. As expected, prevalence rates for all three substances increased over time, but the rate of increase for tobacco and marijuana use was less for adolescents in program schools than for those in control schools. The program was equally effective in reducing drug use prevalence in both high and low risk populations.

Critique

The design, length of follow-up and statistics used made this a very strong study. Thus the findings that *STAR*, the school-based component, reduces tobacco and marijuana use three years later have a high degree of confidence. Reliability measures of the instruments and the use of a "bogus pipeline" to ensure validity strengthen the findings. The "bogus pipeline" informs students that they maybe randomly selected for saliva tests to confirm their reported tobacco use. A replication study in Indianapolis suggest generalization to other Midwestern U.S. sites. No data indicate whether *STAR* would be equally effective in locations with large numbers of students of Hispanic or Asian American decent. It did not reduce alcohol use and measures did not examine its effectiveness in reducing problem use versus social and experimental use.

Evaluation Contact

Dr. Sadina Rothspan
Project Manager
Insitute for Health Promotion Disease Prevention Research
Department of Preventive Medicine
University of Southern California
1441 Eastlake Ave. MS44
Los Angeles, CA 90033-0800
PH: (213) 764-0325

Success For All

Program Description

Success for All (*SFA*) was developed by Robert E. Slavin and his colleagues at Johns Hopkins University to improve the reading and writing skills of at-risk children aged 4-10. *SFA* was started in 1987 at an urban elementary school in Baltimore, Md. By 1996 it was in approximately 300 schools in 70 districts in 24 states, including large urban and small rural districts. Most program sites are low-income, Title I schools. *SFA* is typically funded by reallocation of existing Title I/Chapter I, state compensatory education and special education funds. In order for a school to adopt an *SFA* program, 80 percent or more of all teachers must vote for adoption.

The program's purpose is to bring all children to grade-level standards in basic skills by the third grade. The *SFA* program begins with intensive one-to-one tutoring by certified teachers and paraprofessionals for first-grade students having reading problems. The tutoring consists of 20-minute sessions outside of reading and math teaching periods. The tutors also assist during regular reading class.

The phonically-based reading curriculum emphasizes the development of oral language and uses thematic units. The "Story Telling and Retelling" component involves students listening to, retelling and dramatizing children's literature. When children reach the primer reading level, they spend approximately 90 minutes daily in multi-age groups of students with similar reading skills. In cooperative learning teams students explore story structure, prediction, summarization, vocabulary building, decoding and writing. Every eight weeks students are assessed for progress and needs.

"Family Support Teams," which consists of a Title I parent liaison, principal, counselor, teacher and other support staff work with parents and social service agencies to insure children attend school, have access to medical services, get assistance with behavioral problems and obtain other needed services.

Services Available

Certified teachers and tutors receive three days of in-service training before the start of the program and several follow-up visits and workshops throughout the school year. Other than personnel, typical costs for full-scale implementation include $20,000 for materials and $14,000 for 20 days of training, plus travel, during the first year. Reading materials are available in English and Spanish.

Implications for Practice

Reading is a fundamental academic skill and critical for a student's success in school. Research suggests that early poor performance in reading and retention in the same grade are good predictors of which students will drop out of school. Failure to succeed in school predicts multiple high-risk health behaviors such as substance abuse as well as violent and delinquent behavior. This pattern persists despite students' later enrollment in remedial or special education programs. The *SFA* program is a primary-prevention program that coordinates academic and human services to insure that every child will succeed in school.

Audience		
	P	
	K^3	✓
	4^6	✓
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	K^{12}	
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Locale		
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Level		
	Cl	✓
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Components		
	C	✓
	St	✓
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	Pa	✓
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	P	
	Sk	✓
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Emphasis		
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	N	
	B	✓

Barbara Coppersmith
Success For All Program
Johns Hopkins University
3505 North Charles St.
Baltimore, MD 21218
PH: (800)548-4998 / FAX: (410) 516-8890

Success For All

	E	Design
✓	Q	
✓	I	Analysis
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	M	
	QI	Data
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	F	Type
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Evidence of Program Effectiveness

Six schools in Baltimore and Philadelphia, Pa. and one in Charleston, S.C. have participated in a seven-year multi-site longitudinal evaluation. As new sites have adopted the program, new cohorts have been added using a common evaluation design and the data pooled. To date, a total of 23 schools in eight states and approximately 4,000 students have participated in the program evaluation. Most students were African American, 75 percent to 96 percent of whom were eligible for subsidized lunches. Program schools were matched by reading performance, socioeconomic status, and ethnicity with comparison schools that generally taught standard reading programs.

Beginning in K-1, trained professionals, not linked to the project and who were unaware of school status, assessed children with a high rate of interrater reliability. Assessors used the Peabody Picture Vocabulary Tests, the Woodcock Reading Mastery Test and Durell Analysis of Reading Difficulty. Older students in fourth or fifth grade completed the Gray Oral Reading Test. Analyses of covariance (ANCOVAs) with pretests as covariants compared raw scores in all evaluations. Tests compared cohort means for experimental and control schools. Separate analyses were conducted for all students and for those in the lower 25 percent of their grades based on the Peabody test.

Findings revealed statistically significant positive effects for program students compared to controls on every measure at every grade level from first to fifth. The effects were particularly large for students who were in the lowest 25 percent of their classes. In addition, trend analysis revealed that mean reading effect size progressively increased with each year of implementation. Teachers' increased experience with program implementation, ongoing professional development and coaching, or early, lasting effects of the pre-kindergarten or kindergarten program might account for the increases.

In one school, *SFA* was adapted to meet the needs of children who spoke Cambodian or other Southeast Asian languages. The program integrated the ESL programs with that of the reading program. A cross-age tutoring program enabled fifth-grade students to help kindergarten children succeed in the English program.

Compared to a matched control school, the Asian students in *SFA* significantly outperformed on every measure at every grade level ($p<.001$) as did the non-Asian students in the program school. Another study looked at the Spanish version of *Success for All*, *Lee Conmigo*. ANCOVAs controlling for pretests showed that at the end of second grade, *SFA* students scored substantially higher than did control students on every measure ($p.<01$ or better).

SFA shares many similarities with *Reading Recovery*, one of the most extensively researched and widely used innovations in elementary education. Each employs tutoring by certified teachers and emphasizes "learning to read by reading" as well as metacognitive skills. However, *SFA* tutoring sessions are shorter (20 vs. 30 minutes) and are coordinated with the normal reading classes. An evaluation comparing these two programs in one rural school district found that the programs were comparable for most students but that special education students benefitted more from *SFA*.

Evaluations of *SFA* in Baltimore have found positive effects on attendance. Retention in grade decreased from an average of 11 percent in grades K-3 to near zero. Avoiding retention is a policy of *SFA* rather than an outcome of the program. In 1992-93, a pilot started to ease the transition to middle school for students graduating from *SFA* elementary schools.

Critique

Although the study did not involve random assignment of students to program or control conditions, the quasi-experimental, longitudinal design is robust. *SFA* requires schools to make a serious commitment through policies and funding. This comprehensive program demonstrates that schools and teachers serving disadvantaged youth can, with volunteer tutors and extra resources, provide students with the information and skills they need to succeed in school.

Evaluation Contact

Robert E. Slavin, PhD
Johns Hopkins University
3505 North Charles Street
Baltimore, MD 21218
PH: (410) 516-8816 / FAX: (410) 516-8890

Systematic Screening for Behavior Disorders

Program Description

Dr. Hill M. Walker of the University of Oregon and Dr. Herbert H. Severson of the Oregon Research Institute developed the *Systematic Screening for Behavior Disorders* (*SSBD*) program over a five-year period beginning in 1984. *SSBD* identifies students in grades K-6 who are at elevated risk for developing behavior problems. *SSBD* provides classroom teachers with uniform behavior standards to use in identifying students "at-risk," referring them at a stage when intervention is most cost effective.

Assumptions underlying *SSBD* include: 1) classroom teachers can identify children in need of services; 2) teachers in least restrictive environments are more likely to over refer students with aggressive, antisocial behavior (externalizing) and under refer passive, shy, timid (internalizing) students; 3) classroom teachers' judgements followed by direct observation by mental health professionals is the most efficient way to assess student behavior; 4) screening procedures can be undemanding without sacrificing quality; and 5) two of the major developmental tasks of students that can serve as important indicators of age-appropriate norms are participation in academic tasks and relating to peers.

SSBD employs three increasingly discriminating screening criteria. In Stage I, teachers rank groups of 10 children on behavior disorder profiles. The top three students on the lists then move to stage two. Stage II involves rating students according to severity, frequency and content of behavior problems using three instruments. Only those students who exceed *SSBD* screening stage II criteria progress to Stage III. Those who do not meet the cutoff become candidates for intervention with teacher assistance teams. In Stage III, counselors, school psychologists or other nonteaching professionals observe students in the classroom and the playground for fifteen minutes on two separate occasions on different days. Students who exceed normative criteria for their age and gender are then referred to a child study team for further evaluation. The developers also have a preschool version for ages 3-5 called the *Early Screening Project* and an intervention system for antisocial kindergarten children entitled, *First Steps*.

Over 20 different sites in Oregon, Washington, Utah, Illinois, Michigan, Kentucky, Florida, Texas and Rhode Island have tested *SSBD*. The U.S. Department of Education's Program Effectiveness Panel has approved it as a validated program for distribution by the National Diffusion Network.

Services Available

Awareness materials are available free of charge. A user guide, administrative manual, technical manual, observer training manual, video and materials packet are available. Costs to a district adopting the program involve the purchase of materials ($195) and training ($400 per day). Consumable products are minimal and the program requires no special staff, equipment or facilities.

Implications for Practice

Public Law 94-142, the Education for all Handicapped Children Act of 1975 and its reauthorization, Public Law 101-476 (IDEA) requires public school systems to identify and provide intervention programs and services to all eligible children with disabilities. Children with behavior disorders are consistently ranked by educators as one of the highest service priorities among all the handicapping conditions currently served by the public school system. *SSBD* is a cost-effective tool to identify children early in their school careers whose future achievement and adjustment might suffer without preventive remediation services.

Audience	
P	
K[3]	✓
4[6]	✓
M	
H	
K[12]	
S	

Locale	
R	
U	
S	
M	✓

Level	
Cl	✓
B	
D	
Co	

Components	
C	
St	✓
Pe	
Pa	
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	
N	
B	✓

Rebecca Williamson
Project Director
1140 Boston Avenue
Longmont, CO 80501
PH:(303)651-1751

Systematic Screening for Behavior Disorders

	E	Design
✓	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
	Qn	
✓	B	
	F	Type
	S	
	O	
✓	P	

Evidence of Program Effectiveness

Oregon and Washington school districts conducted the initial development and field trials of *SSBD*. Multiple studies assessed the reliability and validity of the *SSBD* process as a screening tool. Inter-rater reliability among trained classroom teachers for stage I screening ranged from r =.89 to .94. The inter-rater reliabilities of the two *SSBD* stage III observation codes ranged from .9 to .99 for the academic time on task code and .80 to .99 on the peer social behavior/ playground code. Test/retest reliability using Spearman rank order coefficients for stage I rankings averaged .76 for externalizing and .74 for internalizing dimensions. Separate correlations for the Stage II rating scales averaged .88 and .83. Measures correctly classified 89 percent and 84 percent of the subjects, respectively, as externalizers, internalizers or non-ranked controls. Discriminate and concurrent validity compared *SSBD* with other well known measures such as the Achenbach Child Behavior Checklist.

The current study examined whether achieved outcomes matched those in prior research and compared the amount of time spent implementing *SSBD* to existing referral and assessment procedures. Three comparison schools in the same district in Utah were involved. Schools were equivalent by socioeconomic status and student achievement. The entire teaching faculty from the program schools received training in Stages I and II assessment. Eighteen Stage III observers received three hours of training using videotapes. They worked with a calibration observer until they achieved a minimum of 80 percent inter-observer agreement before collecting data on their own.

Fifty-eight program teachers completed Stage I screening for 1,446 first- to fifth-grade students. Those teachers identified 475 (33 percent) students in Stage II and referred 225 (16 percent) for observation. The Stage III assessors observed each referred child twice for at least 12 minutes on the playground and in the classroom during independent seat-work time following structured reading, mathematics, social studies, or language periods. Observers stopped the stopwatch whenever the child's behavior did not meet the criteria of academic engagement and restarted it when the student resumed. Time on task was calculated by dividing the actual engaged time by the total amount of time observed.

Similar procedures were followed for playground observations. Over 900 observations were made with average inter-observer agreement 95 percent. The top two students for both externalizing and internalizing behaviors in each classroom were evaluated for services. To compare *SSBD* with the comparison schools' standard procedures, evaluators reviewed files of 58 students with behavioral disorders, considering all required forms and data used for certification purposes. They estimated the time necessary to accomplish each item or task in the procedure based on an assessment matrix developed by the school following Utah regulations and guidelines for determining special education eligibility. The comparable analysis for the amount of time required for the *SSBD* procedure included the professional time involved in all three *SSBD* stages and the time involved in making assessment and placement decisions based on that information.

The study results confirmed that *SSBD* is a reliable procedure for systematically screening and identifying elementary school students potentially at risk for either internalizing or externalizing behavior disorders. Studies also documented that it is an accurate screening and identification procedure that discriminates students with potential behavior disorders in regular classrooms. *SSBD* required less professional time than traditional referral and assessment processes. Teachers preferred it as an initial screening device and felt that it was more equitable than traditional methods because it considered all children's possible need for special services.

Critique

The evaluation studies demonstrated the reliability and validity of *SSBD* in identifying young students needing special services. No studies have followed students referred to determine long-term benefits of early referrals and interventions based on this system.

Evaluation Contact

Dr. Herbert H. Severson
Oregon Research Institute
1715 Franklin Blvd.
Eugene, OR 97403
PH: (541) 484-212

Teen Talk

Program Description

Teen Talk is a pregnancy prevention curriculum for multiracial adolescents aged 13-19. Developed by Dr. Marvin Eisen in the early 1980s and based on the Health Belief Model and social learning theory, the program addresses adolescents' awareness of the chance of becoming pregnant or causing a partner to become pregnant; the negative personal consequences of teenage pregnancy; and the personal and interpersonal benefits of delayed or protected intercourse. It also seeks to decrease participants' perceptions of barriers to abstinence and consistent contraceptive use.

Content of the 12- to 15-hour curriculum covers reproductive physiology, contraceptive methods and their effectiveness. Small group discussions also help teens understand and personalize the risks and consequences of unplanned pregnancy. Other strategies include games, role plays and trigger films that show teenage actors involved in sexual decision-making, and practice of refusal skills. Participants generate their own scripts for role-playing key sexual and contraceptive-related situations. The authors recommend two days of staff development for those who teach the curriculum with an emphasis on effective group discussion skills and current content.

Sociometrics, Inc. selected *Teen Talk* for its Program Archive on Sexuality, a collection of promising prevention programs. The Texas Department of Human Services, the University of Texas at Austin, the Hogg Foundation for Mental Health, the William and Flora Hewlett Foundation and the National Institutes of Health supported the development and evaluation of *Teen Talk.*

Services Available

The program is available through Sociometrics, Inc. at a cost of $195 and includes all student materials, a training manual and videos for discussion leaders, pre/posttests, a directory of local evaluators and technical support by phone for one year.

Implications for Practice

Unplanned pregnancies among adolescents have concerned public officials since the 1960s. Since the discovery of AIDS in 1982, sexuality education has taken on a new urgency. Few events are as life-changing as pregnancy or a diagnosis of HIV infection. *Healthy People 2000* objectives 5.1 and 5.2 address the issues of adolescent unintended pregnancies. Objectives 5.4, 5.5, 5.6 and 5.7 are risk reduction objectives that focus on reducing the number of sexually-active youth, reducing the frequency of sexual activity, and increasing the use of effective contraception. Objective 5.8 encourages parents to discuss their sexual values with their children and schools to provide sexuality education.

Numerous programs have attempted to delay sexual activity or increase contraceptive and condom use among adolescents. Effective curricula generally teach specific skills, are derived from a theoretical framework, address peer norms and provide opportunities to practice skills in a structured environment. *Teen Talk* meets these criteria and seems to be most effective with sexually-active males – a group that is often difficult to reach and likely to be resistant to change.

Audience	
P	
K^3	
4^6	
M	✓
H	✓
K^{12}	
S	

Locale	
R	
U	
S	
M	✓

Level	
Cl	✓
B	
D	
Co	

Components	
C	✓
St	✓
Pe	
Pa	
M	
P	
Sk	✓
Se	

Emphasis	
K	✓
A	✓
N	
B	✓

Dr. Marvin Eisen
Sociometrics Corporation
170 State Street, Suite 260
Los Altos, CA 94022-2812
PH: (415)949-3282

Teen Talk

✓	E	Design
	Q	
✓	I	Analysis
	G	
	B	
	D	
	C	
	M	
	QI	Data
✓	Qn	
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	F	Type
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✓	O	
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Evidence of Program Effectiveness

Teen Talk was developed and field tested in the early 1980s as a small-scale pilot program without a comparison group. Encouraging results led to a larger evaluation in 1986. Seven agencies in Texas and California that offered family planning services and one school district agreed to participate. The agencies ranged from an urban Planned Parenthood affiliate to a rural health clinic. Agencies recruited youth by their usual means, then randomly assigned them to either the *Teen Talk* program or a comparison curriculum. The school involved eighth- and ninth-grade students.

The sample consisted of 1,444 youth (52 percent female; 24 percent African American; 15 percent White, 53 percent Hispanic and 8 percent Asian). Researchers used a standardized, pretested instrument during individual interviews to collect baseline and follow-up data. In addition to demographic information, the instrument assessed sexuality-related knowledge, attitudes, beliefs, intentions and behaviors. With a mean age of 15.5 at pretest, 37 percent were sexually-experienced and nearly half reported using contraception at their last intercourse (74 percent used a condom). Over half (67 percent) reported previous sexuality education. There were no significant differences between groups with respect to demographics, background, beliefs, knowledge or previous sexual behavior.

Both curricula covered reproductive biology, contraception, STDs, and sexual decision-making. In addition, *Teen Talk* focused on the four major conceptual components of the health belief model and used more extensive role plays and active involvement of students. Of those surveyed at baseline, 92 percent received all or part of the programs and completed Time 2 measures, a pencil-and-paper test of knowledge and beliefs. At Time 3, a year later, staff re-interviewed 888 youth representing 62 percent of the original sample and 67 percent of the Time 2 sample. Multivariate analyses revealed that program participants had significantly greater knowledge than the comparison group on the immediate posttest but did not differ on health beliefs.

Among the 567 youth who were virgins at pretest and who completed all three surveys, 167 (29.5 percent) reported becoming sexually active by follow-up one year later.

In addition, 39 of the 262 youth (15 percent) who were sexually experienced at pretest reported no sexual intercourse during the follow-up period. There were no differences by program type or age group. Females were more likely to remain abstinent than males (77 percent vs. 61 percent, $p<.001$). Female virgins at pretest who participated in *Teen Talk* and became sexually active were less likely to use an effective contraceptive method at most recent intercourse than were those in the comparison group, who relied heavily on condoms (60 percent). It was unclear whether this was due to the program or to their partner's choices. Among females in both conditions, those who used contraceptives consistently at pretest, those who had sex education before and those who reported fewer perceived barriers to birth control use were more likely to continue contraception at follow-up. Among sexually-experienced males, both groups improved their use of contraception but those exposed to *Teen Talk* improved significantly more, with other variables controlled.

In summary, prior sexual experience and gender mediated outcomes of the curriculum. Sexually-active females in both groups improved their use of contraception. Males participating in *Teen Talk* improved their contraceptive practices more than those in the comparison groups, although both groups improved. The evaluators concluded that prevention programs might need tailoring for specific groups.

Critique

This study revealed few differential effects for the program. In one instance, the participants in the comparison group showed more favorable behaviors than those in the program group. Because the comparison groups also received sexuality education of comparable length, their intervention might have resembled the treatment, reducing any detectable effects of *Teen Talk*.

Evaluation Contact

Dr. Marvin Eisen
Sociometrics Corporation
170 State Street, Suite 260
Los Altos, CA 94022-2812
PH: (415)949-3282

Wary Walker

Program Description

Wary Walker is a pedestrian safety program for elementary-school children developed by Harborview Injury Prevention and Research Center with support from the Maternal and Child Health Bureau and the National Highway Traffic Safety Administration. The program has two components – a school-based K-3 curriculum consisting of five 40-minute classroom sessions and an outdoor field day and a two-part activity workbook to be completed at home with the family. During the outdoor field day, students are videotaped crossing a street, then watch themselves in the classroom to critique their safe crossing behavior.

The K-1 curriculum teaches the basics of crossing the street safely and obeying traffic signs and signals. The activity workbook encourages parents to go with their children and identify "safe" places to walk, play and cross the street. Given the developmental limitations of young children, the workbook focuses on activities such as identifying the edge of the road when there is no sidewalk or curb, teaching about "go zones" (safe places to walk), and looking the driver in the eye before crossing the street. Classroom activities include songs, dances, games and "real life" practice. The workbook for second to third grade focuses on problem-solving situations such as crossing the street safely at a blind spot and at a corner. Children and their families design "safe maps" to school, the baby-sitter's home and a friend's house.

The program teaches specific skills that counter the most common causes of pedestrian crashes for elementary children: stopping at the edge, searching left-right-left for traffic, searching while crossing, searching around visual barriers, and communicating with motorists. The course also provides opportunities to deal with some ambiguous circumstances faced by young pedestrians. For example, students learn how to find the safest place to cross when there is no crosswalk, what to do if a car comes down the street after they have already started to cross and how to find out if the driver of a stopped car sees them before they begin to cross.

The program involves the community by using a multi-faceted approach to solve the problem of pedestrian injuries and deaths. Materials suggest ways to include the school's parent organizations, media and community educators in a safe pedestrian campaign. The curriculum also encourages teachers to look at public education, engineering and enforcement strategies to assure a safe pedestrian environment.

Services Available

The curriculum, which costs $75, contains lessons, posters, parent-child activity books, slides, photocopy masters of activity and coloring books, videotapes and audiotapes of songs. Other materials include a *Wary Walker and the Careful Crossers* coloring book, brochures, flyers, posters, public service announcements, instructions for a pedestrian safety rodeo, parent and youth group guide, and community guide.

Implications for Practice

Unintentional death is the leading cause of death among elementary school-aged children in the United States. Automotive crashes involving children as passengers or pedestrians account for the majority of such injuries. *Healthy People 2000* calls for reducing deaths caused by motor vehicle crashes, including those to pedestrians. The target for pedestrian fatalities is a reduction from 2.8 deaths per 100,000 people to 2.0 deaths per 100,000 people. Currently, cars hit an estimated 500,000 children annually. Street crossing involves a complex series of actions with as many as 25 discrete tasks. Children require training to safely maneuver in traffic areas. School-based education programs such as *Wary Walker* can promote a safer pedestrian environment for children.

Audience		
	P	
	K^3	✓
	4^6	
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	H	
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	S	

Locale		
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	S	
	M	✓

Level		
	Cl	✓
	B	
	D	
	Co	

Components		
	C	✓
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	Pe	
	Pa	✓
	M	
	P	
	Sk	✓
	Se	

Emphasis		
	K	✓
	A	
	N	
	B	✓

Luann Ambrosio
Harborview Injury Prevention and Research Center
325 Ninth Ave., ZX-10
Seattle, WA 98104-2499
PH: (206) 521-1534 / FAX: (206) 521-1562

Wary Walker

	E	Design
✓	Q	

✓	I	Analysis
	G	
	B	
	D	
	C	
	M	

✓	QI	Data
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Evidence of Program Effectiveness

Three public elementary schools in Seattle, Wash. participated in field tests of the program during two academic years. Seattle public schools serve approximately 20,600 elementary children: 46 percent white, 25 percent black, 21 percent Asian, 6 percent Latino and 3 percent Native American. Approximately 40 percent live with one parent and 40 percent receive free or reduced-price lunches. Selected schools had high pedestrian injury areas, adequate class sizes, substantial numbers of children walking home from school and interest in the program. A pedestrian safety specialist implemented the program. The children received six training sessions, including two outdoor practice sessions, and a follow-up assembly to review procedures.

The evaluation assessed four street crossing behaviors by observing 229 students 10 days before and 10 days after *Wary Walker* training. Observation sites were not protected by a crossing guard or student patrol and were used frequently by children. The students had no knowledge of the observations. Observations were made of the same children pre/post-intervention. Children's performances were compared with their own pre-training performances, rather than with their peers. This unique approach helped offset the small number of children observed.

Before training nearly all children walked on the sidewalk, fewer than 50 percent stopped at the curb, 25 percent searched and less than 20 percent kept looking. The program had its greatest impact on the proportion of children who continued to look for cars while crossing. At baseline 10 to 18 percent of children looked, whereas post program, three times that number continued to look ($p<.01$). During the second year, the parent component was added resulting in significant increases in the number of children who looked before crossing. The program slightly improved the proportion of older children who stopped at the curb, but did not improve the proportion of younger children who did so.

Researchers concluded that children's pedestrian skills can be improved somewhat, but that education programs must be part of a broader effort if pedestrian injuries are to decrease. Facilities' design, public awareness and enforcement of laws must accompany the education effort.

Critique

The evaluation report provided no information about inter-rater reliability. All observations took place near the school which might not represent a child's behavior elsewhere. Nonetheless, naturalistic observations are preferable to paper and pencil tests. Fidelity to the curriculum was not an issue as the teacher was hired for the study, however, with classroom teachers the results may be less positive. A comparison group would strengthen the conclusions attributable to the program. The *Wary Walker* evaluation gives some insight into what skills children need and demonstrates that education is not the only component of pedestrian safety that schools should address to insure the safety of children.

Evaluation Contact

Luann Ambrosio
Harborview Injury Prevention and Research Center
325 Ninth Ave., ZX-10
Seattle, WA 98104-2499
PH: (206) 521-1534 / FAX: (206) 521-1562

Young & Healthy

Program Description

Young & Healthy began in 1990 as a community outreach project of All Saints Episcopal Church in Pasadena, Calif. *Young & Healthy* provides free medical, dental and mental health services to uninsured, low-income children - 28 percent of the students - in the Pasadena Unified School District. The typical child served is a 10-year-old Latino elementary school boy or girl whose primary language is Spanish, living with both parents, at least one of whom is working, and three siblings.

The project operates through the school nurses' office in all 32 schools in the district and has expanded to include homeless shelters and day care centers. Local pediatricians, other specialists, optometrists, physical therapists and podiatrists volunteer on a rotational basis to provide medical treatment in their offices. Health care providers agree in advance to see a set number of free patients each month and forms travel to the care provider with the child to track referrals, diagnosis and recommendations and follow-up needs. Some physicians have accepted clients on a long-term basis. Volunteer dentists provide acute dental services. A dental prevention education program teaches first-grade students to care for their teeth. Funds have been donated to underwrite a mobile dental clinic to provide comprehensive dental care to 120 students with the greatest need annually.

Mental health services are available in two elementary schools with plans to expand therapeutic services district wide. A mental health consultant works with school personnel, students and parents. Volunteer licensed mental health professionals and interns provide free counseling to students who need on-going care. A full-time social worker, with a team of volunteers, provides case management to all referred children seen by a provider. The case manager works with the parents to remove barriers and help obtain additional or on going care for the children.

Local pharmacists provide free prescriptions, and a local laboratory provides free lab tests as recommended by participating physicians. Funds have been donated to cover follow-up medical costs for special procedures such as lab work, x-rays and related services not readily volunteered. Trained community volunteers assist the school nurses with a variety of tasks, work in the *Young & Healthy* office, provide translation and transportation services, and participate in the Dental Prevention Education Program. A group of pediatricians and mental health professionals provides educational seminars for parents during various times and on a variety of topics. Child care services and translators also are provided.

The cost of the program implementation in Pasadena, in 1994-95, was $272,218 with an additional $421,220 contributed in-kind. The cost includes a full-time executive director supported by a full-time assistant, a case manager, nurses, development director and part-time clerical staff.

Services Available

Information packets are available for less than $5 and a video describing the program cost $13. Training costs are negotiable. *Young & Healthy* staff can provide consultation by phone.

Implications for Practice

For many school districts and communities, the problem of health care services for children is not one of availability, but rather of affordibility and accessibility. *Healthy People 2000* has two objectives related to these issues: 21.3 - "increase to at least 95 percent the proportion of people who have a specific source of ongoing primary care for coordination of their preventive and episodic health care" and 21.4 - "improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling and immunization services recommended by the U.S. Preventive Services Task Force." Approximately one-third of the children living in Pasadena have no health insurance, a situation typical of most communities across the country. The program model of developing a cadre of volunteer physicians, dentists, optometrists and other health care professionals represents an invaluable strategy for expanding and enhancing affordable and accessible services for students who otherwise would not receive essential assistance.

Audience	
P	
K^3	
4^6	
M	
H	
K^{12}	✓
S	✓

Locale	
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S	✓
M	

Level	
Cl	
B	
D	
Co	✓

Components	
C	
St	✓
Pe	
Pa	✓
M	
P	
Sk	
Se	

Emphasis	
K	
A	
N	
B	✓

Mary Donnelly-Crocker
Executive Director
Young & Healthy
351 S. Hudson Ave.
Pasadena, CA 91109
PH: (818) 795-5166 / FAX: (818) 795-8154

Young & Healthy

Design: [ ] E [✓] Q

Analysis: [✓] I [ ] G [ ] B [ ] D [ ] C [ ] M

Data: [ ] QI [ ] Qn [✓] B

Type: [✓] F [ ] S [✓] O [ ] P

Evidence of Program Effectiveness

To date, the *Young & Healthy Project* has conducted process evaluations every year as the major form of program assessment. In the first year of operation (1990), the *Young & Healthy* office arranged 227 appointments for physical health services. By year two it arranged 628 appointments with 113 physicians, 11 dentists, 23 mental health professionals, nine pharmacies, one podiatrist, four optometrists, one eye glass company and one laboratory. By 1994-95, it provided 2,305 referrals for 1,039 students representing 4,794 units of service. Case management services, dental care and mental health services saw similar increases in the number of children served. None of the health care providers who have participated in this program have withdrawn and new providers are added every year. The number of volunteers also continues to increase. Parent participation at educational sessions is another indicator used by the project to measure success. Attendance at these sessions has seen a slow, but steady increase attributed to positive word-of-mouth publicity. In 1994-95, attendance increased by 31.5 percent over the previous year.

Because health and learning are so closely interconnected, and children cannot learn when they are absent or distracted due to illness, the project selected absentee patterns as a measure of project impact. Three evaluation questions were examined:

- After referral, does the number of absences from school decrease?
- After referral, does the length of each absence episode decrease?
- Do any initial decreases in the number or length of absences persist over time?

A sample of 640 students was tracked from fall 1993 until spring 1995. Findings were mixed. Compared to baseline data from fall 1993 when there were an average of 2.6 absences among students served, the number of absences increased to 4.0 in fall 1994 and 4.3 in spring 1995.

The evaluators speculated that there may have been more absences due to initial and follow-up appointments or diagnostic procedures. Students referred in the fall showed a significant increase in absences during fall semester, but by spring their absences decreased significantly. Regardless of grade, family structure or ethnicity, the number of absences decreased in the semester immediately following initial referral to *Young & Healthy.* The length of the absences did not appear to be affected by referral.

Explanations for these findings include the suggestion that as health problems were identified, there was a short term need to miss school to address the problems, but that in the long term the child's health was sufficiently improved to decrease absences. Absences remained relatively high due to more and more children being referred into the system as the school year progressed. No long term follow-up has been done.

Critique

Evaluating the value of medical care to children in a community can take many forms. From the perspective of enhancing access to services for low-income families, *Young and Healthy* has sufficient evidence of success. They have provided essential services for students who otherwise would not receive assistance by capitalizing on pro bono professional time. This is a pioneering effort that can serve as a model for other communities and school districts to follow.

The complexity of the services offered requires a sophisticated evaluation design. Unfortunately, the evaluation design and data collected to date do not allow for a rigorous examination of program logistics and cost effectiveness. It is not yet possible to determine the program's impact on the health status of the children it serves.

Evaluation Contact

Vital Research
8380 Melrose Ave.
Los Angeles, CA 90069
PH: (213) 653-7441

Youth AIDS Prevention Project

Program Description

Designed as a middle-school curriculum to prevent sexually transmitted diseases (STDs) including HIV infection and substance abuse among urban youth, the *Youth AIDS Prevention Project* (*YAPP*) is also appropriate for community-based organizations serving youth aged 12-14. Using the theory of planned behavior, the social influences theory and social cognitive theory to predict behavioral change, the program targets teens' knowledge, attitudes, self-efficacy, intentions and behaviors regarding high-risk sexual and drug-taking behaviors.

The program consists of ten sessions in seventh grade, usually in a health or science class for two consecutive weeks, plus a five-session (one week) booster in eighth grade. Classes cover transmission and prevention of STDs including HIV infection, the importance of using condoms for those who choose to have intercourse and the development of decision-making, resistance and negotiation skills. In addition to lectures and class discussions, *YAPP* uses active learning techniques that include small group exercises, role-plays of specific situations, demonstrations of condom and foam use, and anonymous questions from a question box. Some homework assignments provide opportunities for parental involvement. The developers recommend that *YAPP* teachers hold at least a master's degree in health education, have training in HIV and AIDS prevention education and additional training on the *YAPP* curriculum.

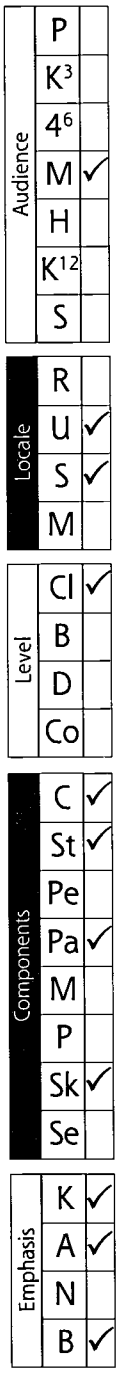
Sociometrics, Inc. selected *YAPP* for inclusion in its Program Archive on Sexuality, a collection of promising prevention programs. The National Institute of Mental Health provided funding for the development and evaluation of *YAPP*.

Services Available

The *YAPP* program package, available from Sociometrics, costs $590. Included is a user's guide, curriculum manual, student workbooks, activity cards, two videos, a parent packet, evaluation instruments and supplementary information. In addition, limited technical support by telephone, regarding program implementation and evaluation is available.

Implications for Practice

Presently, one quarter of new HIV infections in the United States occur in young people aged 13-20. In addition, twenty percent of AIDS cases diagnosed are among those aged 20-29. Given the long incubation period between initial infection and AIDS diagnosis, a large percentage of people diagnosed with AIDS in their 20s probably became infected with HIV as teenagers. In the absence of a vaccine, education programs such as *YAPP* remain the most hopeful strategy to reduce HIV infection and increase protective behaviors among adolescents. *YAPP* addresses numerous *Healthy People 2000* objectives including the reduction of both the incidence (18.1, 19.1, 19.2) and prevalence (18.2) of HIV infection and other STDs; increasing the proportion of sexually active, unmarried persons who used a condom at last sexual intercourse (18.4, 19.10); the provision of age-appropriate HIV education as part of a quality school health education (18.10, 19.12); and the reduction and disapproval of drug use (4.5, 4.6, 4.13).



for materials:
Program Archive on Sexuality
c/o Sociometrics Corporation
170 State Street, Suite 260
Los Altos, CA 94022-2812
PH: (415) 949-3282

for information:
Susan R. Levy, PhD
Prevention Research Center
850 West Jackson, Suite 400
Chicago, IL 60607
PH: (312) 996-7222
FAX: (312) 996-2703

Youth AIDS Prevention Project

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Evidence of Program Effectiveness

A 1991-1993 study examined *YAPP*'s effect on students' self-efficacy and practices related to the prevention of HIV/AIDS and other STDs. Fifteen school districts were selected from among 45 districts in the greater metropolitan Chicago area considered at greatest risk for HIV infection. Selected districts were randomly assigned to one of three conditions: a parent-interactive group, a parent non-interactive group or a delayed program/control group. Because of difficulty obtaining parental involvement researchers eventually combined the two program groups into one group.

A total of 2,392 seventh-grade students (1,459 program and 933 controls) completed pretests. At pretest, students in both the program and control groups had consumed alcohol at similar levels (46 percent) and approximately 33 percent had already had sexual intercourse. The posttest sample decreased to 1,669 by the end of the eighth grade (32.4 percent attrition for program and 29.6 percent for control). Although, those lost to attrition differed from those included, in terms of baseline tobacco and alcohol use and sexual activity, those lost in the program and control groups appeared similar in demographic and other behavioral characteristics.

Trained data collectors administered surveys in the classroom. The survey instrument addressed refusal self-efficacy ("How comfortable or uncomfortable would you feel refusing marijuana offered to you at a party?"), use self-efficacy (assertiveness in obtaining condoms or foam), and practices and behavioral intentions that put students at risk of HIV infection. Skilled health educators who received additional training in delivery of this program conducted all classroom educational sessions. The control classes received the HIV/AIDS prevention education normally offered in their school.

Fifty percent of the students remained abstinent by the eighth-grade posttests and approximately 19 percent became sexually active between the seventh and eighth grades. Reported data focused on students who became sexually active during the study period. Students in both the program and control groups changed in self-efficacy and behavioral intention, but the program group changed more.

Four out of 10 program effects significantly exceeded those of the control students. *YAPP* students were more likely to feel comfortable obtaining condoms or foam than those in the control group and to say they "definitely will" or "maybe will" use condoms and foam. Following the booster session in eighth grade, *YAPP* students were more likely than the comparison students to report using condoms with foam.

YAPP did not effect self-efficacy for using refusal skills or other practices likely to reduce the risk of HIV infection such as carrying and using condoms. Because researchers could not document what HIV education students in the control schools received, that education might have contributed to the lack of differences between groups. The youth subculture in the study districts accepted alcohol and marijuana use as well as sexual intercourse, creating a norm that could reduce refusal self-efficacy among program students. In order to establish positive social norms and overcome peer influences, programs may need to begin at even earlier ages if they are to strengthen self-efficacy.

Critique

This well-designed curriculum and robust evaluation design found no positive impact on sexual practices of already sexually active youth. A ceiling effect might have contributed to the lack of differences. At pretest, sexually-active students had a fairly high level of condom use (over 70 percent that increased to over 80 percent at post test in both program and control schools). Students exposed to *YAPP* who subsequently became sexually active did, however, have more positive intentions to practice protective behaviors. Evidence that behavioral intent and future sexual behaviors have any correlation is tenuous. A longer follow-up study might demonstrate a relationship between the program and less risky practices later in adolescence.

Evaluation Contact

Susan R. Levy, PhD
Prevention Research Center
850 West Jackson, Suite 400
Chicago, IL 60607
PH: (312) 996-7222 / FAX: (312) 996-2703

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Appendix A: Guidelines for Reviewers

American School Health Association/Office of Disease Prevention & Health Promotion
School Health: Findings from Evaluated Programs
Second Edition

GUIDELINES FOR REVIEWERS

Reviewers Information (name, title, institution, address, etc.)

Instructions: Please evaluate the extent to which the program under consideration meets the following criteria. The comments and questions following the criterion are meant to be illustrative, not all inclusive. A program must achieve a minimum score of **30** in order to be accepted into the second edition but it does NOT have to have been successful in order to be included; we can learn as much from failure as success. We are interested in well done studies from which we can learn important lessons. Five on the score means an exemplary component, a one means very poor. If a particular component scores a 3 or less, please indicate your concerns in writing in the space provided directly below the item.

Criteria of Effectiveness

Evaluation Design A good evaluation design assures that the results have been obtained in a manner appropriate for the program and that the effects are clearly produced by the program. The appropriateness of the comparison between "treatment" and "no treatment" is critical.

5 4 3 2 1 *Appropriate Measurement* Instruments and measurement procedures are valid for the program and have adequate technical strength. Qualitative and quantitative data collection and analysis procedures have been appropriate and carefully handled. Explanations are offered as to why tools/methods were selected and reliability and validity was determined.

Comments:

5 4 3 2 1 *Attribution* It is critical that the link between program elements and observed outcomes is clearly established. Do evaluators consider other explanations for findings? Have they controlled for competing influences, threats to validity and recognized potential weaknesses?

Comments:

5 4 3 2 1 *Comparison Standard* Is the standard for comparison appropriate? A comparison group should be similar to the group involved in the program and appropriately selected to minimize bias. Norm-referenced measures help establish true program effects.

Comments:

SUBTOTAL:

Meaningful Results Do the findings from the evaluation contribute to our understanding of what works or doesn't work in attempting to improve the health status of children and youth and those who work in school-based settings? Are the goals of the program worthwhile? Are the issues being addressed substantive?

5 4 3 2 1 *Need* Does the program address one of the six critical issues for adolescents identified by the Centers for Disease Control and Prevention? Does it address one on the Healthy People 2000 objectives? Does it address one of the national education goals? Does it contribute increased knowledge based on timeliness of results, efficient use of resources, or creative use of methods and strategies? Are the findings of practical, applied value? Does it provide insights into a hard-to-reach group? Is the program rationale clearly linked to the larger purpose it seeks to serve?

Comments:

5 4 3 2 1 *Distinctiveness* How is this program similar to or different from other programs? Are the outcomes what one would expect from a similar program or better? Is there a discussion of similar programs and their results? Is additional supporting evidence or corroboration offered for the claims made?

Comments:

5 4 3 2 1 *Difficulty* The more difficult and complex the problem being addressed, the longer it is likely to take to see measurable change. Not all important variables are easily measured and some consideration must be given to the effort made to obtain compelling evidence that the program is on the right track. Changing behavior is clearly more difficult than increasing information.

Comments:

SUBTOTAL

Potential for Replication The program should be appropriate for other, similar sites at a reasonable cost in both time and money - with the expectation of similar results.

5 4 3 2 1 *Generalizability* Has the program been replicated in more than one setting? Does it work with different age groups or racial groups, in different geographic settings, in parochial as well as public settings? A program may be tailored to one age group or racial group but still have been tried at more than one site with the same targeted group. Does it require "special" circumstances to work?

Comments:

5 4 3 2 1 *Efficiency* Are the requirements of the program - time, money, human and material resources - reasonable within the context of the real world? If the impact is truly significant, it may be expected to cost more but an effective program strives to use available resources efficiently relative to the expected outcomes.

Comments:

SUBTOTAL

GRAND TOTAL

In your opinion, should this program be included in the Second Edition of *School Health: Findings from Evaluated Programs?* Comments:

Things to Consider When Writing About the Program

- Was a theory involved in planning and/or implementation of project? If yes, identify and describe application.
- Which risk factors were addressed?
- Who was the targeted audience: students (pre-kindergarten, primary, intermediate, middle or high school, special); faculty/staff; parents/families; or community/school?
- Was non-print media; e.g., computer, video, theater, etc. a component of the project?
- What strategies were used; e.g., skills training, peer instruction, mentoring/tutoring, service learning in the community, parents involvement, community agency linkages?
- How long has the program been operational; how long was the program operational before being evaluated?
- To what extent were parents/families involved in planning and/or implementation?
- Where was the program implemented: home, school during school hours, school during after-school hours, community?
- To what extent were the following factors considered: literacy, gender, ethnic diversity, cultural diversity, English as a second language?
- Were program implementors trained prior to implementation? How long?
- Who implemented the program; e.g., classroom teacher, counselor, peers, parents, combination, graduate student, specially-trained non-school-based professional, other?
- How is the program funded, what are the principle costs in time and human resources?
- Were products and/or materials produced for possible distribution to others seeking to replicate? Name contact person and cost if readily available.
- What were the linkages into community?
- To what extent were community health professionals involved in program planning and/or delivery?

Appendix A: Guidelines for Reviewers

Things to Consider When Writing About the Evaluation

- Describe the demographic characteristics of those involved. How many were involved initially and how many completed?
- What was the method of selection and or assignment to treatment group?
- Was the reliability and validity of instrumentation established?
- Were qualitative measures used; e.g. focus groups interviews?
- Identify the type of statistical analysis used to determine effectiveness?
- What was the measure of success; e.g., knowledge gain, attitude shift, or behavior?
- What was the unit of analysis; e.g. individual, classroom or group, building, district or community?
- Were any environmental variables considered influential in affecting outcomes; e.g., mass media, geographic location, etc.

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Achieve						●				●	9-10
Athletic Health Care Systems	●							●			11-12
Be Proud! Be Responsible					●				●		13-14
Becoming a Responsible Teen					●				●		15-16
California's 5-A Day Power Play	●	●									17-18
CATCH PE	●										19-20
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Children of Divorce						●					23-24
Coca-Cola Valued Youth Program						●					25-26
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Developmental Approaches in Science and Health (DASH)			●		●						31-
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Get Real About AIDS									●		37-38
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Evalutated Programs	*HEALTHY PEOPLE 2000* SELECTED PRIORITY AREAS										PAGE NUMBER
	PHYSICAL ACTIVITY	NUTRITION	TOBACCO USE	ALCOHOL & OTHER DRUGS	REPRODUCTIVE HEALTH	MENTAL HEALTH	VIOLENT BEHAVIOR	UNINTENTIONAL INJURY	STD/HIV	CLINICAL SERVICES	
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School Development Program						●					89-90
Seattle Social Development Project						●					91-92
Social Competence Promotion						●					93-94
Social Decision Making						●					95-96
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Students Taught Awareness and Resistance			●	●							101-102
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Evalutated Programs	COMPREHENSIVE SCHOOL HEALTH PROGRAM COMPONENTS								PAGE NUMBER
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Achieve						●			9-10
Athletic Health Care Systems					●				11-12
Be Proud! Be Responsible!	●								13-14
Becoming a Responsible Teen	●								15-16
California's 5-A Day Power Play	●			●					17-18
CATCH PE					●		●		19-20
Child Development Project	●						●		21-22
Children of Divorce			●				●		23-24
Coca-Cola Valued Youth Program	●								25-26
Community of Caring	●						●		27-28
Decker Family Development Cntr.		●					●		29-30
Developmental Approaches in Science and Health (DASH)	●								31-[illegible]
EAT SMART				●					33-34
Florida Traffic and Bicycle Safety	●								35-36
Get Real About AIDS	●								37-38
Gimme 5	●								39-40
Going for the GOAL	●								41-42
Good Touch/Bad Touch	●								43-44
GRADS	●								45-46
Healthy for Life	●								47-48
High/Scope Perry Preschool	●								49-50
I Can Problem Solve	●								51-52
Increasing Bicycle Helmet Use	●								53-54
Jeffco Middle School Life Science	●								55-56
Kansas LEAN				●					57-[illegible]
Mediation in Schools	●								59-60

Evalutated Programs	COMPREHENSIVE SCHOOL HEALTH PROGRAM COMPONENTS								PAGE NUMBER
	HEALTH EDUCATION	HEALTH SERVICES	PHYCHOSOCIAL SERVICES	FOOD/ NUTRITION SERVICES	PHYSICAL EDUCATION	ENVIRONMENTAL/ ADMINSTRAION	FAMILY& COMMUNITY	FACULTY/ STAFF WELLNESS	
Multnomah Coounty (OR) SBHCs		●					●		61-62
Oregon SHBCs		●					●		63-64
Parents and Adolescents Can Talk	●						●		65-66
Positive Adolescent Choices Training	●								67-68
Primary Mental Health Project			●				●		69-70
Primary Prevention	●								71-72
Project for Attention-Related Disorders			●				●		73-74
Project Northland	●								75-76
Project Taking Charge	●								77-78
Project TNT	●								79-80
Rapping with Vince and Larry	●								81-82
Reach Out to Schools	●								83-84
Reconnecting Youth	●								85-86
Resolving Conflicts Creatively	●		●						87-88
School Development Program						●	●		89-90
Seattle Social Development Project	●					●			91-92
Social Competence Promotion	●		●						93-94
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SCHOOL HEALTH

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